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meat earlier in life*

Clinical studies *give evidence of benefits of feeding Swift's Meats for Babies to babies as young as 6 weeks. Here are results of feeding tests with Swift's Meats for Babies, conducted by doctors at leading universities and hospitals.*

* Babies *digest* the nutrients of meat as easily as milk *and* Babies *utilize* the nutrients in meat as well as in milk. *Sisson, Emmel and Filer, "Meat in the Diet of Prematures," Pediatrics, 7,89, (1951).*

* Babies have high-normal hemoglobin concentration when fed meat. *Leverton and Clark, "Meat in the Diet of Young Infants," J.A.M.A., 134, 1215, (1947). Also Andelman, Gerald, Rambar, and Kagan, "Effects of Early Feeding of Strained Meat to Prematurely Born Infants," Pediatrics, 9, 485, (1952).*

* Babies allergic to milk proteins can substitute a formula made with meat. *McQuarrie and Ziegler, "Nutritive Value of Mineral-Enriched Meat and Milk," Pediatrics, 5, 210, (1950).*

Top source of protein. Swift's Meats for Babies are all meat, prepared for maximum retention of meat's nutrients: complete, high-quality protein, B vitamins, and food iron.

Easy for baby to eat. Swift's Meats for Babies can be fed by spoon at 6 weeks, or mixed with formula earlier. Strained so finely, they flow right through the nipple of a nursing bottle.

Easy to feed. The 7 different kinds tempt baby's appetite, help him learn to like a variety of meats early. When baby drinks these meats in his formula, he gets used to their flavour and texture before he reaches the "balky" stage.

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**If you would like a reprint of any of these studies, write Swift Canadian Co., Limited, Dept. S.M.B., Toronto 9, Ontario.*

These clinical studies are part of a continuing program, originated by Swift to help provide the medical profession with specific facts on feeding meat *earlier* in the infant diet. Because of the benefits indicated by these tests, many doctors start babies on meat at 2 or 3 months. Some pediatricians recommend meat as early as 2 weeks—mixed right into the infant's formula.

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Between Ourselves

Have you a green thumb when turned loose in a garden? If so, you will feel a kindred interest with our guest editor this month, **Esther Irene Paulson.** Collecting a slip of this, a cutting of that, even when she is away on trips, carefully tending and nurturing them until they are safe in her own beautiful garden in West Vancouver, is a favorite pastime for this busy president of the Registered Nurses' Association of ***British Columbia.***

Born of Swedish parents, Miss Paulson was educated in New Westminster and graduated from the Royal Columbian Hospital there. She worked on the staff in her own hospital for a couple of years before taking a post-graduate course in obstetrical nursing at the Royal Victoria Montreal Maternity Hospital. Four years later she qualified for her public health nursing certificate at the University of British Columbia. She engaged in public health work in both rural and urban centres before turning to specialization in tuberculosis for the past ten years. Miss Paulson is presently director of nursing with the B.C. Division of Tuberculosis Control and acting superintendent of nurses of the Pearson Tuberculosis Hospital in Vancouver.

As spokesman for her province, Miss Paulson sketches a picture of the developments in professional nursing that merits the interest of every reader. This, the third largest nurses' association in Canada, has a most active program that is participated in by the membership to a remarkable degree. Read about it.

* * *

This month again, we are concentrating on a study of many diverse aspects of ***obstetrics and obstetrical nursing care.*** In Canada, 30 years ago the birth rate was 29 per 1,000. Before and during the years of the depression it dropped continuously until, in 1937, it was 20 per 1,000 of the population. Since then, owing to economic recovery and especially during the war years, it rose appreciably. The recent figure of 27 per 1,000 places Canada as tenth in a tabulation of the major countries of the world from which figures are available. Newfoundland has the highest provincial rate—36.3—and British Columbia has the lowest—24.

Hospitalization and medical attendance at birth have increased in our country. In 1926, only 22 per cent of live births occurred in hospital while in 1948 the proportion was 72 per cent. The provinces differ greatly in this latter respect, ranging from British Columbia, 96 per cent, down to Quebec, 41 per cent. Less than 5 per cent of live births in Canada are illegitimate. Approximately one confinement in 85 results in the birth of more than one child.

Interesting as these statistics may be, the immediate problem of the nurses is the provision of nursing care. To help take care of the 28 per cent of infants who are born outside of hospitals the information provided here regarding home deliveries will be particularly pertinent.

The importance of breast feeding cannot be overstressed. We have no figures on the proportion of babies that are breast fed but if our powers of observation are not failing us, it is not high. Nurses have a real responsibility here.

* * *

Recently, word has reached our National Office of the activities of ***one of the graduates of the Metropolitan School of Nursing*** at Windsor—**Ruth Patterson.** Like countless other Canadian nurses, Miss Patterson journeyed far afield. We will let her tell you herself what she has been doing and plans to do:

> "I have been in Belgium for several months now. I am studying French preparatory to going to the Belgian Congo, Africa, to do missionary work. Perhaps you are interested to know about the Tropical Medical Course which is given here twice yearly. All Congo medical personnel are required to take the course. It includes: tropical medicine, tropical hygiene, helminthology, hematology, pharmacology, entomology, pathology, bacteriology, anatomy, and physiology."

We are hoping that Miss Patterson will write about her work when she becomes established.

Through inadvertence, we neglected to note that the article in our January issue, "Suppose Tommy Won't Eat" by Mrs. G. T. Haig of Winnipeg, had been presented during a symposium on Nutrition at the convention of the Canadian Public Health Association last year. We regret this oversight.

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New Products

Edited by PROFESSOR F. N. HUGHES

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

AEROSPORIN BRAND POLYMYXIN B SULPHATE

Manufacturer—Burroughs Wellcome &. Co., Montreal.

Description—Contains 0.1% (10,000 units in 1 cc.) Aerosporin in acidified propylene glycol.

Indications—In the treatment of ear infections.

Administration—For adults, 3 to 4 drops should be instilled into the affected ear three or four times daily; for infants and children, 2 or 3 drops are suggested.

ANECTINE BRAND SUCCINYLCHOLINE CHLORIDE INJECTION

Manufacturer—Burroughs Wellcome & Co., Montreal.

Description—An ultra-short-acting skeletal muscle relaxant. Following intravenous injection of small doses (10-20 mg.) the relaxation persists approximately three minutes. Because of its short duration of action, Anectine is more controllable and, therefore, safer than the longer-acting muscle relaxants now in general use.

Indications—For the production of muscle relaxation during surgical procedures and in conjunction with electroshock therapy. Prolonged relaxation may be obtained by repeated injections or, preferably, by maintaining a continuous intravenous drip.

Administration—Neostigmine and other anticholinesterases do not antagonize the action of Anectine but, on the contrary, prolong its effect; they are, therefore, contraindicated as antidotes. Facilities for controlled respiration and for the administration of oxygen should always be immediately available.

BECOBARB ELIXIR

Manufacturer—Frank W. Horner Limited, Montreal.

Description—Vitamin B compound with phenobarbital, in elixir form. Each 5 cc. teaspoonful contains:

Phenobarbital	16 mg. (¼ grain)
Thiamine	2 mg.
Riboflavin	0.5 mg.
Pyridoxine	0.2 mg.
Niacinamide	10 mg.
d-Panthenol	1 mg.

Administration—One or two teaspoonfuls 3 or 4 times a day or as directed by the physician.

CORICIDIN COMPOUND

Manufacturer—Schering Corporation Limited, Montreal.

Description—Each tablet contains: Chlor-Tripolon maleate 2 mg., Acetylsalicylic acid 0.23 gm. (3½ gr.), phenacetin 0.15 gm. (2½ gr.), caffeine 0.03 gm. (½ gr.), Codeine phosphate 8 mg. (⅛ gr.).

Indications—In the treatment of the common cold, of allergic conditions, the control of cough, and as a sedative analgesic for the relief of mild or moderate pain.

Administration—One or two tablets every 4 to 6 hours.

ERYTHROCIN

Manufacturer—Abbott Laboratories Ltd., Montreal.

Description—Each tablet contains 100 mg. Erythrocin (Erythromycin, Abbott), new antibiotic effective particularly against Gram-positive organisms. Has low toxicity.

Indications—Infections such as pharyngitis, tonsillitis, scarlet fever, erysipelas, pneumococcic pneumonia, osteomyelitis, pyoderma, etc., due to susceptible organisms. Especially suggested for infections by organisms which have become resistant to penicillin.

Administration—Orally, average adult dose 100 to 300 mg. every 4 to 6 hours. In severely ill patients doses up to 500 mg. may be repeated at 6-hour intervals if necessary.

PRUSOL

Manufacturer—Frank W. Horner Ltd., Montreal.

Description—Contains: Acetophenolisatin (laxative component of prunes), methylcellulose, and natural prune gels.

Indications—For relief of functional constipation; gently stimulates peristalsis without colonic irritation.

Administration—One or two tablespoonfuls with water twice daily.

New Products

HYDROCORTONE Tablets

Manufacturer—Merck & Co. Ltd., Montreal.

Description—Each oval tablet contains 20 mg. Hydrocortisone Merck (17-hydroxycorticosterone).

Indications—Rheumatoid arthritis.

ILOTYCIN

Manufacturer—Eli Lilly & Company (Canada) Ltd., Toronto.

Description—Each tablet contains 100 mg. Ilotycin (Erythromycin, Lilly), new, potent, wide-range antibiotic produced from a strain of *streptomyces erythreus*. It is a white, odorless, bitter, crystalline compound, soluble 2 mg. per cc. of water; stable at room temperature.

Indications—Effective clinically against staphyloccoci, hemolytic streptococci, pneumococci, and certain non-hemolytic streptococci. Tests show activity against syphilis, rickettsial diseases, pertussis, gonorrhea, and possibly brucellosis. It has low toxicity and enters the spinal fluid more readily than does penicillin.

Administration—Orally, recommended dosage 300 to 500 mg. every 6 hours for adults—may be exceeded in cases of resistant organisms. In children, 6 to 8 mg. per kg. of body weight is minimum dose.

P. G. A. 500

Manufacturer—The British Drug Houses (Canada) Ltd., Toronto.

Description—Each scored tablet presents 500,000 I.U. penicillin G ammonium.

Indications—Infections due to penicillin-sensitive organisms. (The parenteral use of penicillin should continue to be used in overwhelming infections where massive doses are required.)

Administration—One tablet two or three times daily, one half-hour before or one and one-half hours after meals.

PLEXONAL

Manufacturer—Sandoz Pharmaceuticals Ltd., Montreal.

Description—Each coated tablet contains:

Sodium barbital	45 mg.
Sodium phenobarbital	15 mg.
Sodium Sandoptal	25 mg.
Dihydroergotamine methanesulfonate	0.16 mg.
Scopolamine hydrochloride	0.08 mg.

Indications—As a hypnotic or daytime sedative.

Administration—Hypnotic, 1 to 3 tablets ½ hour before bedtime. Sedative, 1 or 2 tablets 2 or 3 times daily.

RECTO-CAL

Manufacturer—Anglo-French Drug Co. Ltd., Montreal.

Description—*Suppositories for children:* Calcium formate 0.50 gm., Vitamin A 5,000 I.U., Vitamin D_2 1,000 I.U., in a hydrosoluble base; *Suppositories for adults:* Calcium formate 1 gm., Vitamin A 5,000 I.U., Vitamin D_2 5,000 I.U., in a hydrosoluble base.

Indications—Rickets, disturbances of growth and dentition, as an alimentary supplement during pregnancy, for fractures and all conditions wherein calcium is required.

Administration—One suppository morning and night, or according to the physician's direction.

TORYN Syrup, Tablets

Manufacturer—Smith Kline & French Inter-American Corporation, Montreal.

Description—*Syrup:* Each 5-cc. teaspoonful contains Toryn (caramiphen ethanedisulfonate, S.K.F.), 10 mg.; chloroform, 10 mg.; sodium citrate, 325 mg.; alcohol, 4.7%; in a demulcent and mildly expectorant vehicle. *Tablets:* Toryn (caramiphen ethanedisulfonate, S.K.F.), 10 mg.

Indications—Bronchial asthma, whooping cough, croup, tuberculosis, pleuritis, pharyngitis, laryngitis, tracheitis and bronchitis.

Administration—ADULTS AND OLDER CHILDREN: *Syrup*, 1 to 2 teaspoonfuls every 4 to 6 hours; for nocturnal coughs, 2 teaspoonfuls at bedtime. *Tablets*, 1 to 2 tablets every 4 to 6 hours; for nocturnal coughs, 2 tablets at bedtime. YOUNGER CHILDREN AND INFANTS: ½ to 1 teaspoonful every 4 hours.

Even although present civil defence training may never be necessary in Canada, to lessen the effects of an atomic attack, the training now being given to volunteers in most provinces can prove invaluable in the emergencies that often occur in ordinary life.

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1. Perloff, W. H. (1951), Treatment of the Menopause. II. American J. Obst. & Gynec., 61:670, March.

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Nursing Round-up

IT IS A MISTAKE to think of the early years of nursing as a contrast to the present—they were simply the beginning of an evolutionary movement, just as a seed is the beginning of a tree.—Lavinia Dock in *The American Journal of Nursing*, Dec. 1950.

Eminent statesmen and leaders have told us that knowledge of the past is essential to clear our perspective in the present and to direct our planning for the future. Mr. Winston Churchill said, "The past is our guide to the future" and Mr. Justice Holmes said, "Knowledge of the past is not a duty — it is a necessity."

The quotation by Lavinia Dock implies that a spirit of continuity, a link with the past is important in nursing, too. The realization of the need for research suggests that the nursing profession, like other professions serving the people's health needs, must review the past, analyze the present, make provision for changes to meet prevailing needs more effectively, and then plan for the future on that foundation.

On that assumption, then, I shall attempt to review the outstanding changes and developments that have taken place in nursing service and nursing education in British Columbia during the past decade and touch on events in the early days which have led up to the present situation.

For several years after the passing of the first registered nurses' act in 1918,

ESTHER PAULSON

the emphasis was on setting standards for nursing education that would ensure safe nursing care for the public. Further changes in the curriculum and in required clinical experience led to the need for additional educational facilities and supervisory and teaching personnel, with the result that during the decade from 1920 to 1930 most of the small schools were closed. During the same decade the University of British Columbia established a basic degree course in nursing (in cooperation with the Vancouver General Hospital) and two one-year courses for graduate nurses. In 1950 the last of our small schools closed of its own volition. Thus British Columbia now has, in addition to the basic degree course offered by the University, six hospital schools, the smallest of which is operated by a 200-bed hospital.

During the past ten years, the program at the University has been expanded and strengthened. In 1950, what was formerly the Department of Nursing and Health was reconstructed as a School of Nursing and was given a greater degree of autonomy. The curriculum of the basic degree course has been revised to permit greater flexibility in admission and the completion of all requirements for the bachelor's degree in four calendar years instead of five. Facilities for the graduate nurse have been expanded and the requirements made more flexible so that now the graduate nurse may enrol for a one-year program or for a longer period to work toward a degree. Provision is also made for courses to be taken on a part-time basis.

Study and action by the Association has been directed also toward the establishment of more adequate preparation in the basic course for specific clinical fields to meet prevailing community needs for nursing service. For example, in 1945 affiliation in tuberculosis nursing was made a compulsory requirement in the basic course. Recognition of the value of this move to the tuberculosis services and to the community was given by the B.C. Tuberculosis Society when money was set aside for annual prizes to be awarded to a student from each of the schools of nursing, for high standing during the affiliation period. This year the recognition was extended to include the post-graduate field when the Society made a grant of $2,000 to the School of Nursing at the University, to be maintained annually for bursaries to nurses who are being prepared for supervisory positions in the tuberculosis services. This contribution, like other sources of financial aid to students from the Dominion-Provincial Youth Training Bursaries and Provincial Loan Fund, the Federal Health Grants, and from nurses' groups (alumnae, chapters, the University Nurses' Club and the Student Nurses' Association) are indications of joint acceptance of responsibility by the public and the profession for expansion of nursing resources. It is hoped that similar joint planning and effort will lead to better opportunities for adequate preparation in psychiatric nursing for both graduate and undergraduate students.

The Association has taken an active part in developing a training course for practical nurses (nursing assistants). The course is given at the Vocational Institute which is part of the public school system in Vancouver. The Association has representation on the committee which dealt with the legislation for licensing the auxiliary group and has a voice in making the regulations pertaining to the Act.

Expansion of professional responsibilities in nursing practice and nursing education for a growing membership pointed up the need for more effective representation on the council from the province as a whole. The representation had been drawn mostly from the urban areas of Vancouver and Victoria. The 1944 revision of the Act provided for reorganization into districts as a primary step in achieving this broader representation and, hopefully, more effective interpretation and understanding of nursing affairs at the local level.

Awareness of the need for close liaison with the public has been demonstrated during the past decade in various ways—for instance, appointment of lay people on the Educational Policy Committee. Another example is the special pre-convention program, which is planned for the day preceding the annual meeting, to which representatives from allied

professional fields, community and governmental groups are invited. The program for the 1951 meeting included a panel of non-nursing people who discussed the topic "The Community Looks at Nursing." Greater understanding and interest in nursing affairs have been stimulated and the Association has gained a broader viewpoint through sharing our problems with fellow citizens.

It is encouraging that the Association is being recognized increasingly as the official representative of nurses and nursing and is accorded representation on such bodies as the Hospital Insurance Advisory Council, Civil Defence Planning Committee, and the government Committee on Nursing which draws its membership from health, welfare, and educational sources in the government departments and community agencies.

The Association has still another productive source of contact with fellow citizens who are board members of hospitals and health agencies, with whom conditions of employment are discussed as part of the Labor Relations Program which our Association conducts for the benefit of the members. Many opportunities arise at these sessions for interpreting trends in nursing service and nursing education to the public and to our own members.

Similar opportunities are possible through the two private duty directories and the placement service, carried by the Association along with the Labor Relations Program in the Personnel Services Division of our organization. The resources of the Association have been made more readily available to our individual members and nurses are showing an increased tendency to turn to their Association for help and guidance.

The terms of the Act since the 1944 revision have been directed toward the implementation of effective educational standards; to prepare nurses for prevailing community needs in nursing service; and to provide the means for serving the membership in the various ways outlined in the foregoing account. The reorganization to secure province-wide representation and to bring more nurses into active participation was a progressive move, and the only direct means of keeping individual nurses informed on the problems, trends, and developments in their own professional field. Acceptance of responsibility to that end must be personal as well as official through the professional Association if we, as nurses and as citizens, are to fulfil our obligations to the community.

The achievements in each year that passes are part of that evolutionary movement in nursing, spoken of by Lavinia Dock, that will add to the structure on which the professional responsibilities of our organization may be expanded toward better nursing care for the public and broader service to the membership.

ESTHER PAULSON
President
Registered Nurses' Association of British Columbia

A Work Creed

If you work in a profession, in Heaven's name work for it. If you live by a profession, live for it. Help advance your co-worker. Respect the great power that protects you, that surrounds you with the advantages of organization, and that makes it possible for you to achieve results. Speak well for it. Stand for it. Stand for its professional supremacy. If you must obstruct or decry those who strive to help, why—quit the profession. But as long as you are part of a profession do not belittle it. If you do, you are loosening the tendrils that hold you to it and with the first high wind that comes along you will be uprooted and blown away and probably you will never know why.

—*The Nursing Journal of India*

It is a sign of maturity to recognize the need for objective criticism. Far from being disloyal it epitomizes loyalty for it takes a high quality of courage to go against the stream.

—JANET GEISTER in *R.N.* Aug., 1952.

Preparation for Delivery

CHRISTINE E. CHARTER *and* BERNICE GORDON

NOTHING IS DEARER to woman than a nice long, obstetrical chat. I believe, however, that all such discussions shoud be confined to graduate mothers and old maids. For how any woman with a wide circle of helpful female friends produces a child without becoming neurasthenic for life is one of the miracles of Dame Nature, who, we are told, is herself a mother. So many and varied are the taboos and hazards of which her friends gratuitously inform the poor creature that everything she does is bound to be fatal, according to their composite advice, and her days are spent in a blur of bewilderment.

* * *

Cornelia Otis Skinner is entitled, of course, to some exaggeration in that happy little book "Tiny Garments" but in this instance she comes too close to the truth for the comfort of many public health nurses, at least.

It is in an attempt to do away with some of this "blur of bewilderment" among expectant mothers, to assist them, in conjunction with their physicians, to prepare physically and emotionally for having and caring for their babies so that the obstetrical cycle shall be a happy and a memorable time, that the Victorian Order of Nurses in Vancouver has developed the present prenatal program of group teaching.

About 60 mothers-to-be attend the two series of classes which are held twice a week in our attractive new offices, where the rooms are spacious, pretty and comfortable. One series of seven classes provides hourly periods of lecture, discussion and demonstration; the other series is for the purpose of teaching relaxation exercises in preparation for childbearing. The expectant mother is able to attend both classes on the same afternoon, her physician's signed permission being obtained for her participation in the exercise group. Recently a letter from one of the young mothers who completed the series stated: "I had my first baby last night and cannot begin to tell you how pleased my doctor, my husband and I are with the results of the exercises."

This type of combined enthusiasm, frequently encountered, is stimulating to the whole program. Mothers are at their most "teachable" period, eager to learn about themselves, their babies and family living. At two of the seven discussion groups they have the opportunity to hear about the development of the babe *in utero* and the physiology of labor, so that they understand their part in the birth of the baby. The Birth Atlas, published by the Maternity Center Association, New York, is a popular and helpful teaching tool for these classes. The third class deals with general hygiene of pregnancy and preparation of supplies, while at the fourth the mother is given advice and assistance with adequate meal-planning for herself and her family. For help in this field we appreciate the cooperation of the Metropolitan Health Committee, whose nutrition consultant conducts this class.

Hudson's Bay Co., Vancouver

CHRISTINE E. CHARTER

Both authors are actively associated with the program described here that is carried on by the Victorian Order of Nurses in Vancouver.

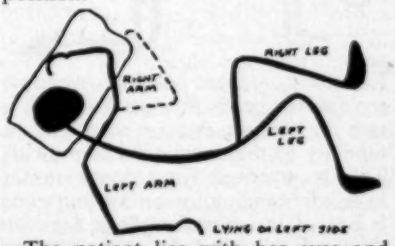
Details of the baby's bath and general care are demonstrated and actively discussed at the fifth session and, as usual, many are the questions answered in the attempt to provide the young mother-to-be with a sense of security in her own performance. The importance and value of breast feeding, the preparation for and techniques of feeding, and the maintenance of the milk supply form the subject of the sixth class, and here the trend towards this method of infant feeding is clearly indicated. At the final session of the series the mothers are assisted with planning a tentative daily schedule for their first days at home with their families. Into this discussion come arrangements for continued medical supervision of the baby, also an attempt to promote the early starting of good habits for parents and babies.

Acceptance of this type of preparation for motherhood has become fairly general but there is now a growing belief that there should be physical preparation for pregnancy and labor as well, and that exercises and methods of relaxation are a most important part of the teaching which expectant mothers should receive, forming an integral part of the whole teaching plan which rightly surrounds expectant families. Labor is a strenuous task, using specific muscles, and producing at its completion the most priceless reward ever gained by hard work. Through our relaxation exercise classes we are striving to make it an experience forever cherished in a mother's memory as one of supreme conscious effort and satisfaction, rather than one of excruciating pain, fear and bewilderment.

The purpose of the exercise classes is threefold: to make the mothers more comfortable during pregnancy, to give them concrete help during their labor, and to aid them in complete restoration during the puerperium.

Picture a classroom, decorated in primrose yellow, with white woodwork surrounding four frosted windows. On the floor are 14 plastic-covered mattresses, each with its pillow and blue flannelette cover. Around the walls are appropriate posters and in one corner is our supply cupboard with the top shelf housing our special reference books.

Let us now go on to the content of the classes in order of teaching. Because the involuntary muscles of the birth canal tense so rapidly when the patient is under emotional strain, thus causing a longer and more painful labor, relaxation is a subject dealt with early in our series. One main cause of tension is fear of the unknown and, in order to allay the mother's fear of labor, a comprehensive discussion of the sequence of happenings during labor is included in the series of lecture classes. However, in a world where the accelerated pace of living induces taut nerves, we feel that our expectant mothers should also be taught how to relax. They are encouraged to consciously relax during each midday rest period so that when the first stage of labor begins—a time when a woman should remain relaxed in order to maintain a relaxed cervix—she will be prepared to do so naturally. In order to attain such physical relaxation, every part of the body must be comfortably supported, with each joint slightly flexed so that there is no strain between opposing sets of muscles. The patient lies on her side, upper arm and leg relaxed forward on to the mattress, and the under arm and leg relaxed in a crooked position.



The patient lies with her eyes and mouth gently closed and face and throat muscles consciously sagged. While she is resting in this position the question of mental relaxation is discussed. Because it is impossible to dispel from the mind all thoughts, we must find some non-stimulating focus for them. It has been found that concentrating on one's own breathing is one of the simplest methods of inducing mental relaxation. Its steady rhythm has a self-hypnotic effect and sleep often follows. The mothers are taught to spend 15 to 20 minutes each day relaxing in this posi-

tion and to lie in this position during the first stage of labor as it will probably be the most comfortable one for them.

The exercises and methods of breathing taught may be divided into those that are of special use during pregnancy, those of use during labor, and those of value during the puerperium.

One thing about which every expectant mother is concerned is her posture and silhouette. As a mother's centre of gravity gradually changes with the growth of her baby, she may tend to become "sway-backed," causing unnecessary strain on the broad ligament by which the uterus is attached in the lumbar region. This brings on backache. By the use of diagrams and demonstration we illustrate the difference between standing with buttocks and lower abdominal muscles slack, pelvis tilted forward, and standing with buttocks and lower abdominal muscles contracted, pelvis tilted up in front, making it a long basket which gives support to the growing baby. Carriage is more graceful, silhouette more streamlined, and aching backs frequently relieved when mothers sit, stand, and walk in this position.

Alternating these positions by slowly rocking the pelvis forward and back is also done as an exercise to encourage mobility of rather rigid pelvic muscles. This is practised lying down on the back, or standing, or on all fours and is one of the most beneficial exercises taught. It is suggested that the mothers use the exercise when standing at their kitchen sink or tables, or when washing floors on all fours. Other pelvic exercises that employ different muscle attachments are also explained.

Sitting tailor-fashion and squatting are two positions practised in class and ones which may also be worked into the daily household routine. Knitting, sewing, or paring vegetables may be done while sitting tailor-fashion, while each time an article is taken from a bottom cupboard or a toddler is lifted the mother should squat. During pregnancy, hormonal action causes softening of the cartilage between the bones of the pelvis and the slight natural enlargement is promoted by assuming these positions. Stretching of the perineum is accomplished as is also toning of the adductors, internal rotators, and glutei.

For those mothers who are threatened by varicose veins a position is demonstrated which relieves venous pressure in the legs and sends fresh blood coursing through them. They are taught to lie on their backs with buttocks next to the baseboard and legs at a 90-degree angle up the wall. Fifteen minutes in this position and aching legs are much relieved.

Of equal benefit is the resting position shown to mothers who complain of a feeling of pain and/or congestion in the pelvic region, groin, and upper thighs. This is usually caused by pressure of the baby, low in the pelvis. If the mother assumes a position with heels elevated on a solid object, two to two and a half feet high, her body maintained in a sloping plane from heels to head, buttocks cupped in her hands, the pressure of the baby is gently released from the pelvis and again the circulation is stimulated in the large blood vessels and the congested feeling is relieved.

The preparation we give our mothers for delivery consists, for the most part, of methods of breathing which are helpful at various stages of labor. The type of breathing that is utilized during the first stage is called "abdominal breathing" or, more specifically, "diaphragmatic breathing." Singers, swimmers, and wood-wind instrument players are taught to breathe with their diaphragms because a long, deep, controlled breath is thus achieved. The benefit reaped from breathing diaphragmatically during first-stage contractions are many and varied. The abdominal wall is gradually raised during the breath intake and abdominal muscles remain relaxed so that the contracting uterus,

as it wells up, meets no resistance. The deep controlled breath causes increased oxygenation of both mother and baby, of special benefit to the latter at this time.

Having something concrete to do during each contraction, something which the mother knows to be beneficial and something which takes concentration, has an excellent psychological effect. Through practice in class and at home, most of the mothers increase their breath capacity from five seconds inspiration and five seconds expiration to 20 seconds inspiration and 20 seconds expiration. One mother who recently attended our classes, and who has now delivered her baby, said that toward the end of the first stage of labor she was becoming tired of doing this type of breathing and decided to breathe normally during a contraction. The pain she felt sent her thankfully back to abdominal breathing with her next contraction.

During the final eight to ten long, hard contractions of first stage of labor when the cervix is attaining full dilation, a woman passes through what is termed the *transition stage*. Her abdominal breathing is no longer effective. She will probably experience severe backache, perhaps some nausea, and it is a time when many patients need sedation. Demerol is frequently ordered by physicians at this time. As well as easing the backache, it is helpful for its specific relaxing effect on the cervix. It does not cause loss of consciousness or initiative. Taking long, deep, gulping costal breaths, called "athletic breathing" because of its similarity to the breathing of an athlete as he collapses over the tape at the end of a long race, appears to be the only thing that helps. Our mothers have these difficult eight to ten contractions explained to them so that they will realize that the transition will last usually only 30 to 45 minutes at the most and then they will pass into the more satisfying and less painful second stage.

Our class on second stage of labor explains the pushing mechanism so that the mother will have some basic knowledge to supplement her instinct at this time. When a contraction begins, she is taught to take a deep breath, hold it and then bear down. In this way she will be able to give a harder, more sustained push. The position which a woman assumes during contractions in the second stage may greatly aid her progress. Lying comfortably on the side in a relaxed position is most advantageous during first stage but for second stage, before draping with sterile sheets, lying on the back with the knees drawn up and held by hooking the hands under them is more effective. This resembles the position of squatting which primitive women assumed to deliver their babies. During contractions on the caseroom table, the mother may draw her knees up and grip the handles on the sides of the table.

One factor that may retard labor at this point is failure to relax the muscles of the pelvic floor. Tensing the muscles of the vagina and perineum against the pressure of the baby's head is quite natural and the mother must be trained to guard against it. In order to create greater elasticity of the muscles of the pelvic floor, and also to aid the mother in her contest with these muscles, an exercise has been devised. For a few minutes each day the mother lies on her back, legs outstretched and ankles crossed. To a slow count of ten, she contracts the thigh muscles, the muscles in the buttocks, and finally the muscles of the rectum, perineum, and vagina, drawing in as though to prevent a bowel movement. Just as slowly the muscles are relaxed. This final state is the one which the mother should maintain during second-stage contractions and also as the baby is being born. The diligent practice of the exercise tends to reduce the need for episiotomies.

Our final aid for labor is a simple method of breathing to be used as the baby's head is in the perineum. If the mother bears down with her contraction at this time, the perineum may be stretched too quickly and danger of tearing or need of episiotomy arises. The force of the contraction is sufficient to slowly force the baby along. The doctor is frequently heard to tell his patient, providing she is able to cooperate—"Do not push." It is very difficult for a mother to abstain from bearing down when every fibre of her body is straining to get the birth over with. By taking

short shallow breaths called "panting," the mother is given a way to prevent herself from bearing down, for it is not possible to do both at the same time.

The final phase of our exercise teaching deals with the puerperium, for we want our mothers to return to optimum health following the birth of their babies. Prime concern is for the shrinking uterus to return to its antiflexed position. Each day following the birth of the baby, our mothers are instructed, with the permission of their doctors, to lie over on their abdomens—preferably with two pillows under their hips—thus promoting drainage of the uterine lochia and antiflexing the uterus. The abdominal breathing that was practised during pregnancy may also be helpful following delivery. However, when the breathing is done several times each day, the mother should try to swell out her abdomen when inhaling and draw it in when exhaling. This is one of the mildest but most effective ways of returning the lax abdominal muscles to normal once again.

Other muscles that have lost their tone and need restoration are those of vagina and perineum. The exercise of alternately contracting and relaxing the pelvic floor muscles is the most effective way of restoring the birth canal to its pre-pregnant firmness.

Into the explanation of these exercises is interwoven some anatomy and physiology, with detailed discussion of the physical and emotional aspects of labor. Here again our main teaching aids are The Birth Atlas and several life-size charts showing cross-sections of the female figure at various stages of pregnancy.

While it is too early as yet to be able to evaluate this series with any degree of accuracy, we are receiving from the mothers, following delivery, completed questionnaires which are given to them at the last class of each course. From their comments we have received quite sufficient indication of their satisfaction to encourage us in continuing the classes. Those of us who have been working with these young mothers have also discovered it to be a most interesting, happy, and rewarding experience.

Ectopic Pregnancy

JEAN BLYTH

TUBAL OR ECTOPIC pregnancy, one of the major complications of the pregnant state, occurs about once in every 300 cases. The word "ectopic" means literally "out of place" and in this case signifies that the fertilized ovum, instead of traversing the length of the Fallopian tube to reach the uterine cavity, becomes implanted in the wall of the Fallopian tube. Since this tubal wall is not sufficiently elastic to allow the fertilized ovum to grow and develop there, the wall eventually ruptures.

Most frequently, rupture occurs into the lumen of the tube and the products of conception with considerable blood pass out of the fimbriated end of the tube into the peritoneal cavity—so-called "tubal abortion." Or the rupture may occur through the peritoneal surface of the tube directly into the peritoneal cavity, again delivering blood and the tubal contents into the abdomen.

Occasionally an ectopic pregnancy may develop in that part of the tube which passes through the uterine wall. Very rarely, in this "interstitial pregnancy" the product of conception, after rupturing through the tubal wall, may implant itself on the peritoneum and develop to full term in the peritoneal cavity. This rare occurrence is known as "abdominal pregnancy" and a surprising number of living infants have, in such cases, been delivered by abdominal incision.

Mrs. Blyth received her obstetrical training in Scotland.

Ectopic pregnancy may be due to any condition which narrows the lumen of the Fallopian tube. The tube may be large enough for the spermatozoa to ascend but too small for the fertilized ovum to descend to the uterine cavity. Any previous inflammatory process of the tubal mucosa, or of the external peritoneal surfaces of the tube causing kinking, may result in narrowing of the tubes. Developmental defects, too, may produce the same effect.

The diagnosis of ectopic pregnancy is seldom made before rupture and then it is of the utmost importance that it be distinguished from a threatened abortion. In both cases there is a history of early pregnancy, irregular bleeding, and sharp, cramp-like pain. Points of difference are:

1. The incidence of abortion is greatest between the second and third month of gestation, while tubal pregnancy may be found as early as the fouth or sixth week.
2. The bleeding in tubal pregnancy is usually moderate in amount and often chocolate colored, indicating the death of the fetus. In contrast, the bleeding in uterine abortion is frequently quite profuse and bright red.
3. In tubal gestation the pain is rarely colicky, is often referred to the affected side, and may be accompanied by faintness or vomiting due to peritoneal irritation. The pain in abortion is rhythmical and cramp-like, resembling labor pains.
4. Examination of the uterine contents would, in a case of abortion, reveal both chorionic villi from the fertilized ovum and decidua but only the decidua would be present in an ectopic gestation.
5. The hormonal tests are of value for diagnosis only when they are positive. A negative result, however, does not eliminate the possibility of an ectopic gestation, as a hormonal test will become negative on the death of the ovum and the separation of the chorionic tissue from the tubal wall.

Ectopic pregnancy is a grave complication and, if a woman who has had one ectopic episode becomes pregnant again, she is more likely than the average woman to have another such accident.

The treatment of ectopic pregnancy is removal of the tube, supplemented by blood transfusion. Early recognition by the nurse of the gravity of the symptoms and prompt measures to combat shock while such a patient is being transported to hospital or awaiting operation may help to save the patient's life.

Placenta Previa

A. H. KERWOOD

THE PLACENTA is a fleshy organ that develops during the third month after conception takes place. Receiving its name from the Latin word for cake, it increases steadily in size during the pregnancy until at full term it may weigh a pound, being roughly an inch thick and eight inches in diameter. Since the placenta is the organ through which oxygen and food material reach the growing fetus and to which the waste materials brought from the fetus by the umbilical artery return, its primary structure is a multitude of blood vessels. A smooth, glistening membrane covers the placenta on the fetal side. The maternal surface, divided into a number of small segments, is a red, spongy mass.

In the great majority of pregnancies, the placenta is attached to the wall of the uterus. However, once in about every 500 pregnancies, the area of attachment will be below the normal site and will be found, either wholly or in part, fixed to the lower uterine segment—in the dilating part of the uterus. When it is in this position, the term placenta previa is applied.

There are three varieties of placenta previa: *marginal*, where only the edge of the placenta reaches to the internal os; *partial*, when the internal os is partially covered; *central* or total, when the placenta completely covers the os.

The cause of placenta previa is unknown though many theories have been advanced. It has been found that it occurs more frequently in women who have had endometritis. Multiparas are more likely to have a placenta previa than is a primipara. The main symptom is painless, apparently causeless bleeding, commencing generally in the third trimester. Occasionally, profuse hemorrhage may be the first indication. While the most frequent cause of bleeding during the early months is abortion, after the seventh month the most probable cause is the presence of a placenta previa.

Even as recently as ten years ago, placenta previa was viewed with profound alarm. With 15 to 20 per cent of maternal deaths attributable to this cause, the concern was justified. Today, with newer methods of treatment being practised, the chemotherapy that is available, plus the fact that blood banks have been established in so many communities thus increasing the availability of blood for transfusions, the mortality from this cause has been appreciably reduced.

Modern treatment methods start with the general agreement that all cases of antepartum bleeding should be admitted to hospital promptly and the physician notified. The patient is kept in bed and as quiet as possible. If the bleeding is profuse tightly apply sterile vaginal pads with a T-binder. Reinforce them as necessary but *do not remove them.* In all cases of placenta previa there is a risk of puerperal infection due to the close proximity of the placental site to the vagina and the lowered resistance of the patient if she has lost much blood.

A complete blood picture, made as soon as possible, will reveal any anemia that may be present. Compatible blood may be given, if warranted. As a general rule, no vaginal examination is made until after the 37th week of the pregnancy in order to avoid precipitating a delivery until the baby has a good chance of survival. If, however, very serious or continuous bleeding occurs, investigation by vaginal examination may be necessary earlier.

A careful external palpation of the uterus is made to determine the position of the fetus. Any abnormality in the presentation—the head high, the head in poor alignment in relation to the symphysis—or frequent changes of presentation make the obstetrician suspicious of placenta previa. Other possible explanations of the bleeding—such as polyps, erosion of the cervix, even cancer of the cervix—are ruled out by speculum examination. X-ray of the pelvis with the patient in different positions will reveal the alignment of the head of the fetus in relation to the symphysis.

Tamponade and dilating bags are obsolete and version nearly so. If the presentation is a breech it is questionable if the membrane should be ruptured. In the great majority of cases the safest and surest method of ensuring the well-being of the mother and the fetus is to resort to Caesarean section if the placenta is either partial or central. For this reason the patient should be examined under sterile conditions in an operating room that is all set up for the Caesarean. Occasionally, where there is a marginal placenta previa, the membranes are ruptured and delivery proceeds normally. Blood should always be available for immediate transfusion.

A safe rule to follow is that every case of painless bleeding in the third trimester is considered a placenta previa until it is proven otherwise. Immediate hospitalization, complete patient inactivity, careful supervision and speedy treatment when the time is right will mean a mother's life saved.

Heartburn during pregnancy, an annoying symptom with little if any significance in mortality or serious morbidity statistics, is nevertheless distressing to the patient who suffers from it. The modern theory for the etiology of heartburn states that the regurgitation of gastric contents into the distal esophagus distends the sensitive neural endings of the esophagus. The distention is further enhanced by intermittent spasm of the cardiac sphincter and causes the symptom.

—Dr. S. C. Kasdon

Pre-eclamptic Toxemia

CATHARINE BLACKLOCK

THE FOLLOWING case record illustrates a complication of pregnancy which is periodically met with. It is pre-eclamptic toxemia, a serious complication that may occur in the latter half of pregnancy. The condition can be fairly combatted but if allowed to continue will develop into eclampsia. It is for this condition that prenatal care is so very essential.

Mrs. Ellis was a well built, ordinarily healthy woman admitted to hospital under staff services. A primipara in her ninth month, she represented a typical case of neglected prenatal care. Her history revealed a weight gain of 60 pounds with edema of the hands for two months and of the ankles for two weeks. She had reported to a doctor's office approximately two hours before admission. On physical examination she showed pitting edema of both feet and ankles up to the knees and edema of the lower abdomen. She was not in labor.

She was extremely cheerful, fairly intelligent and completely unaware of her present serious condition. Immediately she was put in a private room on complete bed rest. She was started on a salt-free diet, 1,000 calories, magnesium sulfate 50% 2 cc. intramuscularly every six hours, penicillin 400,000 units daily, tuinal gr. 3 at bed-time, 500 cc. of 20% glucose in water a.m. and p.m. daily, and sodium amytal gr. 1, three times a day after meals. Fluids were restricted. Everything possible was done to ensure complete rest and elimination of the fluid and toxins. Laboratory tests of blood urea, urinalysis, total serum protein, and quantitative albumin were ordered. Her blood pressure was taken every two hours.

The following morning Mrs. Ellis was x-rayed. This revealed twins at term. The presenting one was a breech on the right and the other was a cephalic on the left. Laboratory reports in the next few days were: Hemoglobin 69%; total serum protein 6.2 gm. % (*normal*—6.03-6.72 gm. %); trace of albumin; blood uric acid 4.3 mg. % (*normal*—1.0-3.5); quantitative albumin .25 gm.

From her admission day, even with complete bed rest and pre-eclamptic treatment, Mrs. Ellis showed very little improvement for three days. There was very severe swelling of the vulva. It was decided that a Caesarean section was the only answer to the problem.

With preoperative medication of Demerol 100 mg. and Hyoscine gr. 1/150, Mrs. Ellis was taken to the operating room at 1:00 p.m. and delivered of male twins of seven pounds, 14 ounces, and eight pounds, two ounces. During the afternoon and evening her condition was considered good. The following day Wangensteen suction was started to prevent any possibility of distention of the stomach. The patient was started on Soneryl suppositories, two every four hours. Her output was 1,650 cc. and Wangensteen 840 cc.; intake by mouth was 540 cc. and by intravenous therapy 1,000 cc.

At midnight, suddenly and without warning, she became convulsive with severe twitching. She was protected from injury. Her blood pressure was 198/150. Administration of sodium luminal gr. 2 seemed to quieten her. Two hours later she had another severe seizure with frothing at the mouth and a blood pressure of 210/180. Following this seizure she became very cyanotic and remained so for several hours. Her pulse was 100 and her blood pressure 150/110. A retention catheter was inserted. Forty cc. of paraldehyde per rectum every three hours, sodium luminal gr. 3 and morphine gr. ¼, alternating every two hours, were prescribed.

On the third day there was albumin two plus in the urine. An enema with sodium bicarbonate was very effective. Mrs. Ellis' condition gradually improved so that by the end of one week she was allowed to sit on the side of the bed. As her elimination improved her brain cleared. The swelling of her ankles and hands subsided. She was discharged within two weeks.

Miss Blacklock is a graduate of Hotel Dieu in Cornwall, Ont.

Confinement Outside of Hospital

JEANIE S. CLARK, M.A., C.M.B. *and* DOROTHY K. MCPHAIL

MOST NURSES, once they have completed their obstetrical training, expect to have little responsibility for the care of maternity patients. However, with the recent development of Civil Defence planning, it appears more than likely that graduate nurses may be called upon to assist with emergency deliveries outside of hospital in time of disaster. With this in mind, the following information is presented as a review of the salient points for the benefit of nurses who have not had recent obstetrical experience.

PREPARATION

It is appreciated that the nurse may reach her patient during any stage of labor and that she may have varying amounts of equipment at her disposal, so that both these factors govern the amount of preparation which she is able to make.

1. ***The patient:*** Do an obstetrical examination first. Determine the stage of labor by the frequency and strength of contractions, inspection, palpation, rectal examination, presence of show and rupture of the membranes.

(a) Check the fetal heart—normal rate 120-140.

(b) Check the mother's T.P.R.

(c) Check the mother's B.P.—probable increases above normal: 10 ml. during labor.

(d) Shave the vulva—for cleanliness.

(e) Give a cleansing enema only if the patient is in the first stage of labor. This helps to stimulate uterine contractions, assures a clean field for delivery and allows more room for the fetus.

(f) Give a warm sponge bath and put a clean gown on the patient.

(g) Do a urinalysis—to check for albumin.

2. ***The bed and the room:*** The furnishings in the room should be as simple as possible. The room should have been recently housecleaned and should be warm.

A. *Bed:* One with a firm spring and elevated on blocks is most convenient. It is made up as follows:

1. Protect the mattress with a rubber drawsheet, brown building paper or newspapers.
2. Cover with a clean sheet.
3. Protect the sheet in one of the following ways:
   (a) 2 rubber and 2 cotton sheets placed alternately (1 rubber and 1 cotton drawsheet can be removed following delivery and the patient will be in a dry, clean, protected bed).
   (b) Homemade pad of newspaper and absorbent cotton, 24″ x 30″, covered with clean linen. This may be baked in the oven or ironed as an added protection.
   (c) Papricloth—a commercially prepared water-resistant paper which can be burned after use.
4. One pillow in a case and one clean top sheet.

B. *Bedpan:* The bedpan should be kept under the bed in a cardboard box, a bag made of newspaper or a paper shopping

JEANIE S. CLARK

Miss Clark secured her midwives' certificate at Simpson Memorial Maternity Pavilion, Edinburgh. She is assistant director of nurses at the University Hospital, Edmonton. Mrs. McPhail holds her certificate in Advanced Practical Obstetrics, University of Alberta. She is assistant director of public health nursing with the Alberta Department of Public Health.

bag. This keeps the bottom of the pan clean so that it does not contaminate the bed when used.

C. *Warm articles:* In front of the fireplace or heater, place:

(1) 2 blankets to cover mother following delivery; (2) 1 receiver—for babe; (3) baby's clothing—shirt, diaper, nightie.

D. *Baby's bed:* The baby must have a separate place to sleep. If a bassinet, carriage, or cot is not available, one may be improvised from a box, washtub, dresser drawer or clothesbasket. Place a firm pillow in the bottom and be sure any sharp edges are covered. Place a hot water bottle in the bed prior to delivery so that the bed and blankets will be warm.

3. *Equipment:* While labor is progressing, the nurse should get ready the following equipment:

A. On a table, trunk or any flat surface near the mother's bed, covered with a clean sheet, place:

1. Gowns and masks for attendant and assistants.
2. Stethoscope—to recheck fetal heart rate.
3. Rectal gloves, for finger cots, and vaseline.
4. Scrub brush, nail file, and green soap.
5. Sterile towels (three) for draping.
6. One package sterile pads.
7. One package sterile swabs.
8. Two 8″-basins in which water has been boiled and allowed to cool. The top basin is removed when delivery is imminent and sterile pads and swabs from package placed in it.
9. Pure Dettol which is added to boiled water in second basin to make 30% solution for hands.
10. Two large kidney basins in which the following are boiled:
   (a) Two hypodermic syringes, intramuscular and subcutaneous needles.
   (b) Two catheters.
   (c) Two pairs artery forceps.
   (d) One pair of scissors.
   (e) One mucus suction with catheter attached.
   (f) Two cord ties—which may be made of tape, twisted linen thread or string.

   The top kidney basin is used to receive the placenta.
11. Dressing alcohol—to cleanse skin for hypodermic injections.
12. Dettol Cream—to cleanse perineum and vulva.
13. The following drugs: Ergometrine ampoules, Demerol ampoules, Ergotrate tablets, Aspirin Co., with codeine.

B. On a small table, chair or box beside the mother's bed place:

1. One chloroform mask.
2. One chloroform dropper bottle.
3. One small towel to protect mother's eyes.
4. One glass of fluid—fruit juice, etc.

C. On a table, box, trunk or any flat surface, covered with a clean sheet, place the following for the baby:

1. Newspaper pad covered with clean linen.
2. Sterile cord ties.
3. Sterile cord dressings.
4. Dressing alcohol.
5. Cord binder, needle and thread (Crepe bandage makes a very comfortable binder).
6. Silver nitrate capsules, 1%.
7. Sterile swabs.
8. Rectal thermometer—to check for imperforate anus.
9. Spring baby scales.
10. Olive oil.

Care of the Patient during Labor

It is important that the patient have confidence in your abilities to give to her and her expected child the necessary care. Even if you are feeling insecure, try to reassure the mother. Explain to her what is going on so that she will be less apprehensive and, therefore, more cooperative. Permit her husband or a member of the family to stay with her if she wishes.

First Stage

1. She will be more comfortable up walking about. If the patient is a multipara with a pendulous abdomen, a snugly fitting many-tailed binder will assist in directing the baby. Thus, the force of the contractions will be better utilized.
2. Offer and encourage the patient to eat light meals and drink plenty of fluids.
3. When labor is well established, 100 mg. of Demerol may be given intramuscularly. Labor is well established when the cervix is three fingers dilated and when strong contractions are coming at regular 3-5 min. intervals. Demerol, 50 mg., may

be repeated twice at three or four-hour intervals provided delivery is not anticipated within two hours. Demerol is an antispasmodic and thus hastens dilatation of the cervix. Also it is non-depressant to the infant.

4. The patient should void every two hours during labor and must not be delivered with a full bladder. A full bladder inhibits uterine contractions and is a predisposing factor to third-stage bleeding and also to retained placenta.

5. A cleansing enema should be repeated after 12 hours if the patient is still in the first stage.

6. Observe the general condition of the patient and watch for show. Recheck the fetal heart rate.

Second Stage

1. The patient should be in bed on her back. She is more comfortable, she can push with her contractions, and the fetal heart can be more easily counted.

2. Do not leave the patient alone after the first stage.

3. Check the progress of the patient. Rectal examinations may be done to assess progress but the nurse should not do vaginal examinations because of the risk of introducing infection. Be sure advance is taking place. Two hours of good contractions in second stage in a primipara and one hour in a multipara should bring about birth.

4. The patient should have sips of hot or cold sweetened fluids.

5. Only encourage her to push when the presenting part is showing. You are then sure she is in second stage. She must not push during the first stage. During a contraction, the patient should draw her thighs up to her abdomen, clasp her hands around her knees and push. If assistants are available they could provide a counter pull by sitting one on either side of the patient and helping her clasp her hands around her thighs. Try to have the patient maintain pushing throughout a contraction but have her relax between contractions.

6. If the membranes have not ruptured by this time, they may be punctured during a contraction. Use sterile forceps but in an emergency even a hairpin may be used.

7. When the head is showing, scrub up and rinse hands in Dettol hand solution.

8. The patient may be postured for delivery by your assistants in one of three ways:

(a) On her back transversely across the bed, with her hips at the edge of the bed and each foot supported on a straight chair.

(b) On her back diagonally across the bed, with one foot on the bed and one foot supported on a chair.

(c) In Sims's left lateral position with the hips to the edge of the bed and an assistant supporting the right leg. If no assistant is available, the right leg may be supported by pillows.

9. Cleanse the vulva and perineum with Dettol Cream.

10. Assist in the delivery of the baby if scrubbed up but otherwise let nature take her course:

(a) Hands off the perineum!

(b) Keep the infant's head flexed by exerting pressure behind the anus with the padded heel of the hand. This gives the perineum time to stretch.

(c) When the head no longer recedes after a contraction, chloroform may be administered if you have an intelligent assistant. Instruct her to pour a few drops on the mask, away from the patient's face, then to hold the mask over the face with her fingers between the mask and the patient's face. This permits air to mix with the chloroform and a state of analgesia rather than anesthesia results. Hence the patient is alert enough to follow your directions. Do not use ether because of the danger of explosion near a flame.

(d) Deliver the head between contractions. Instruct the mother to pant rather than push should a contraction occur.

(e) Let the forehead, face and chin sweep the perineum by releasing the pressure behind the anus and allowing the head to slowly extend.

(f) Wipe each eye with a sterile swab and wipe the nose and mouth.

(g) Feel for cord around the neck. If found attempt to slip the cord over the head. If this is impossible, clamp the cord in two places and cut.

(h) Deliver the shoulders with a contraction. Grasp the head and neck firmly and pull down to deliver the anterior shoulder, then lift up to release the posterior shoulder. Deliver the body slowly and with an upward curve.

(i) Take note of the time and sex. Inform the mother that she has a robust son or daughter. The newborn babe requires the following immediate care:

(i) Lift baby to a dry part of the bed and lower the head.

(ii) Suction the nose and throat before the baby cries. If the baby still has not cried, hold by the feet and sharply flick the soles.

(iii) Tie cord, with two cord ties, using a reef knot at least one and a half inches from the umbilicus. Clamp beyond the ties in two places and cut between the clamps. If there are no sterile instruments available do not cut the cord. The blood will coagulate in the cord and the baby is quite safe attached to the placenta for 24 hours.

(iv) Wrap a sterile dressing around the cord. Put the baby in the warm receiver and place in the cot close by, making sure that the head of the cot is lower than the foot and that the hot-water bottle has been removed.

Third Stage

1. The mother should be on her back. Cover her chest with a warm blanket. Offer her a cup of tea and assure her that, with her assistance, the "afterbirth" will be delivered within a short time.

2. Watch for the signs of separation of the placenta:

(a) The uterus is round and firm and rises in the abdomen and to the surface.

(b) There is a gush of blood.

(c) The cord lengthens and does not slip back into the vagina when pressure is put on the fundus and then released. Never pull on the cord to hasten separation.

3. *When you are sure the placenta has separated*, deliver it with a contraction. Allow the mother to push out the placenta if she has firm abdominal muscles and is not too tired. If the mother is unable to deliver the placenta, instruct her to relax while an assistant uses the fundus as a piston to push it out.

4. Deliver the placenta using both hands and gently twist to release the membranes.

5. Give ergometrine 0.5 mg. intramuscularly.

6. Put a sterile pad over the vulva.

Fourth Stage

1. Because of the danger of hemorrhage, the mother must not be left for the first hour following delivery. During this time the nurse will:

(a) Remove soiled linen so that the mother is on a dry bed.

(b) Add an extra blanket to prevent chilling.

(c) Sit with the patient for one-half hour, holding the fundus and seeing that it remains contracted. If the fundus relaxes, massage.

(d) Offer warm fluids.

(e) Give a warm sponge bath.

(f) Check temperature, pulse and respirations.

(g) Check lochia and change sterile pad. If the patient's pulse is under 90, the fundus is firm and the lochia is normal, the patient may be left at the end of an hour.

(h) Instruct attendant regarding the necessary daily care for the mother and baby until your next visit.

(i) Check the placenta for missing lobes and membranes and then burn or bury.

2. Follow-up care should now be given to the baby:

(a) Check for abnormalities.

(b) Check the cord, retie and dress it.

(c) Instil silver nitrate drops into the eyes.

(d) Identify the baby with a nametape sewn on the wrist or adhesive tape placed on the back.

(e) Clean off crusted blood and dress. Allow the baby to rest for eight hours before putting to the breast.

(f) Place the cot where the mother can keep an eye on the baby.

3. As the attendant at this confinement, remember that the law requires that you notify the local Registrar of Vital Statistics regarding this birth. You should also advise the parents of their responsibility to register this birth.

Complications

This review has discussed the handling of a normal obstetrical case. No attempt has been made to point up the complications that may arise. However, for the guidance of the nurse, medical aid should be summoned if any of the following conditions are observed or arise during the process of labor and delivery.

First Stage

1. Albuminuria: elevated blood pressure

(140/90 or over); edema.

2. Bleeding now or during the past three months.

3. Prolonged first stage—beyond 15 hours for a primipara and 10 hours for a multipara.

4. A patient with a history of heart disease, serious systemic disorder, a previous Caesarean section.

5. A patient who knows she is an Rh negative with an Rh positive husband.

6. Malpresentations and malpositions.

7. Polyhydramnios.

Second Stage

1. No advance of the presenting part.

2. Maternal distress as indicated by: (a) elevated temperature and pulse; (b) brownish vomitus; (c) pinched, frightened look; (d) lack of interest in surroundings.

3. Fetal distress indicated by: (a) an increase or decrease of 20 or more in the fetal heart rate; (b) meconium per vagina; (c) excessive movements followed by no movement.

Third Stage

1. Bleeding.

2. Lacerations of the perineum (an episiotomy is more desirable than a lacerated perineum).

3. Adherent or retained placenta—beyond 20 minutes.

4. Asphyxia neonatorum, prematurity, or intracranial injury.

Fourth Stage

Bleeding.

CONCLUSION

This material has been assembled because of the general reaction among nurses that they have not had adequate instruction to prepare them to competently or confidently care for a patient in labor. The management of labor and delivery is based on a knowledge of mechanisms. A mechanism may be defined as the series of adaptive movements of the fetus in its passage through the birth canal. Obstetrical nurses in Canada are not taught mechanisms and this is the essential difference between our obstetrical training and that of the British midwife.

To provide this instruction for the nurse doing outpost work, for the nurse responsible for an obstetrical unit or caseroom, the course in Advanced Practical Obstetrics was organized at the University of Alberta in 1943. This 16-week course, which was offered during 1952, from September 3 to December 23, covers all phases of antepartum, intrapartum and post-partum care, with experience in the delivery of at least 20 normal cases under medical supervision. This course is providing one means by which the number of qualified obstetrical nurses is being increased in Alberta.

As well as providing a review of the salient points in the management of labor and delivery, it is hoped this presentation has stimulated all nurses to be more alert to the opportunities and need for adequate instruction and supervision of the obstetrical patient throughout pregnancy and the puerperium.

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A Metropolitan Life Insurance study shows that hundreds of fatal accidents to infants could be prevented. Accidents occurring most frequently are due to the swallowing of foreign objects such as nipples, pacifiers, safety pins, buttons and marbles, and to asphyxia through regurgitation of milk and other liquids.

—*R.N.*, Aug. 1952.

For every action there is an equal and opposite reaction. If you want to receive a great deal, you first have to give a great deal. If each individual will give of himself to whomever he can, wherever he can, in the long run he will be compensated in the exact proportion that he gives.

—R. A. HAYWARD

The Nurse and the Nursing Mother

BARBARA (LOGAN) TUNIS, B.N.

TENDER OR CRACKED nipples and difficulty in maintaining an adequate milk supply seem to be fairly common problems for the mother who wants to nurse her baby. She may not be fortunate enough to have a doctor who is a firm believer in nursing but, if she is really anxious to breast feed, there is much that the nurse can do to help her. Just a few words of encouragement—"Hold out a few days longer. Give yourself time to get the supply well established"—can do much to tide the mother over the difficult early days. The first four weeks are the trial period. If the mother can hold on until then, she will almost certainly be able to continue nursing.

This article was prompted by the writer's own experience in nursing two children and it is written in the hope that other nurses will derive from it a more sympathetic understanding of an approach to the nursing mother.

Psychological factors in breast feeding cannot be overestimated. There is a close relationship between worry and the milk supply. Oddly enough, one of the most common reasons for a decrease in supply lies in the mother worrying that she has not enough milk. Since she has no visible means of telling how many ounces the baby has consumed, it is very easy for the mother to imagine, when she hears her infant crying, that she has not enough milk. But how quickly the supply returns when she sees the baby reject a supplementary bottle or the baby may gain half a pound the week she had decided there just wasn't enough in the breast! The nurse can do a great deal to reassure the mother and to advise her regarding rest and extra fluids.

How often we have heard the mother complain, "But nurse, I just haven't time to rest." If she really wants to nurse her baby, the mother will have to take her rest—at least until the milk supply is well established. The metabolic requirements of mothers vary but if hunger is not satisfied thoroughly, or if the fluid intake is insufficient, the milk supply will suffer. Helen Heardman, in her handbook "A Way to Natural Childbirth," gives comprehensive instructions and diagrams for massage and exercise as a means of stimulating the supply. She also advocates contrast bathing of the breasts and all these methods are extremely helpful in the early weeks.

The nurse who deals with the nursing mother must also bear in mind the importance of relaxation and a comfortable position while nursing. Nursing on alternate breasts is often advocated as the most effective method. Nursing on both breasts, however, starting on alternate breasts at each feeding, is equally effective and avoids the lopsidedness of one empty and one full breast. As most of the milk is obtained in the first five minutes of nursing, the starting breast is pretty well emptied at each feeding. The baby must engulf the areola, not merely the nipple and must not be permitted to chew on the nipple. It is also wise to remove the baby from the breast in a gentle manner, by pressing his cheek to make an air passage. The mother at home may become lazy about washing her hands and nipples before nursing; cleanliness should be stressed at all times.

Another important role of the nurse in helping the nursing mother lies in the prevention of complications. The blonde or red-haired woman seems to be more prone to nipple trouble and may, therefore, need extra help. A nipple shield should be used at the slightest sign of a crack. Nipple ointment should not be used exclusively since a tender or cracking nipple requires exposure to the air as well. A 60-watt lamp applied for two to three minutes several times a day

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A graduate of Royal Jubilee Hospital, Victoria, Mrs. Tunis was on the staff of the Victorian Order of Nurses prior to the advent of her own sons.

is a simple procedure and the nurse would do well to bear this in mind when tender, cracked or sore nipples appear.

The use of a glass shield for two or three days will usually give the nipple time to heal and toughen. Gentle massage of the nipple with ointment during this time seems to be helpful and to make it more supple. The infant should be put back to breast slowly, for about one-half minute the first time, followed by the shield, gradually increasing the time if there is no discomfort and the nipple remains in good condition. Often a little supplement or water in the nipple of the shield will start the baby sucking if he is reluctant to draw on the shield.

Should the breast need to be emptied following nursing, as is quite likely with the use of the shield, the mother may use either the breast pump or manual expression. The breast pump can be very uncomfortable and, if the nipples are really cracked or sore, it is too painful to use. Manual expression is actually very simple, causes no discomfort, and can be performed without aggravating the nipples. Mrs. Heardman, again, gives a helpful description of this procedure. Cleanliness, of course, is essential.

With modern methods of treatment, it should be possible for a woman to nurse her baby even after two or three days of manual expression because of cracked nipples or early infection. It seems a shame that more patience and understanding is not shown the mother who really wants to nurse her baby. Too often she is told to wean the baby at the first sign of trouble, without really being given a chance to try.

When one compares the actual nursing time of the baby with the average time spent prenatally on toughening the nipples, one can appreciate that the nipples have to be well prepared for the procedure. Extra emphasis should be placed on care of the breasts after the sixth month, especially in the case of fair-skinned women. As well as daily washing of the nipples and anointing with oil or lanolin, massage of the whole breast, as described in Mrs. Heardman's book, will stimulate the supply. The number of milk ducts functioning can be increased by hand expression and the nipple is drawn out and rolled between thumb and finger. The object is to make the nipple more supple and to accustom it to use.

The nurse on the maternity floor can also be very helpful to the mother. She must, first of all, believe in breast feeding. The nurse's encouragement and her sympathetic attitude toward nursing will help the mother gain confidence in her own ability. The mother may be shy or may find it difficult to adjust to the new status of motherhood. The nurse who takes time to help the baby grasp the nipple, or to assure the mother that the discomfort of engorgement is temporary, does much to allay worry or discouragement. A daily visit from the nursery supervisor is a reassurance to the mother and an opportunity should be given to discuss problems or worries. The breasts should be inspected daily and instructions given for care of the nipples. Fluids are usually provided at frequent intervals but a jug of water beside the bed will save steps and satisfy the mother's need for fluids. She may be extra hungry as well and, as stated above, both hunger and thirst must be satisfied if nursing is to be successful.

One cannot expect that every newborn babe will be of the contented type who does nothing but eat and sleep. On this point as well, the nurse, whether in hospital or home, can do much to reassure the mother. Definite daily crying periods from one feeding through to the next, or even through two feedings, are quite common and may be upsetting to the mother. In this respect, Dr. Arnold Gesell's book on "The Infant and Child in the Culture of Today" is extremely helpful. Every nurse should be interested in his observations on self-demand and normal development. Some form of modified self-demand schedule, especially for the nursing mother, is definitely the most satisfactory to both mother and infant. Another book which could be a handbook for nurses as well as mothers is Dr. Benjamin Spock's popular "Pocket Book of Baby and Child Care." No matter how much theory we know, we cannot be of real assistance to the mother if we do not possess an understanding and human approach, and an ability to interpret our knowledge to the mother on her own level.

Placenta Accreta

CHIZUKO FURUYA

INTRODUCTION

THE NORMAL placenta is a disk-like, vascular organ. It is formed by the chorionic villi and the decidua basalis. By the process of diffusion, an interchange of nourishment from the mother and wastes from the fetus takes place. The waste materials from the fetus are received through the umbilical artery into the placenta, while food and oxygen are returned to the fetus by the umbilical veins. At term, the placenta is expelled by the contraction of the uterus.

Placenta accreta is a very rare condition caused when the chorionic villi have grown into the wall of the uterus and cannot be separated from it.

HISTORY

Mrs. Rubens, aged 33, and a multipara six, who was approximately six months pregnant, was admitted to our hospital on November 2. Her occupation before admission was that of a cannery worker. She has been living in this country for seven months. Before coming to Canada, she lived in Poland and then in Germany. Her husband, who has been here for about a year, is able to support them comparatively well. She has three living children aged 11, 10 and 3 years.

Mrs. Rubens has a history of retained placentas. She states that in her last two pregnancies, the doctors had to remove the placenta manually. In one of her earlier pregnancies, she received blood transfusions, which were given to her directly from nurses who were present during the delivery. During one of these transfusions, she had complained of a severe backache but, when the blood had been discontinued, her backache disappeared.

After her first child, Mrs. Rubens had a severe inflammatory condition in her right breast which developed into an abscess. This abscess had to be incised and drained, taking approximately three months to heal. She was faced with her third pregnancy during the war years, when living conditions were very poor. She felt that two children were all that she could manage so, when she was about three months pregnant, she went to see a person about whom she had heard and received an injection which caused an incomplete abortion to occur three days later. She was then compelled to see a doctor who performed a dilatation and curettage.

During her next pregnancy, she had a therapeutic abortion done, due to her poor health.

PRENATAL CARE

Mrs. Rubens reported to her doctor first when she was about four months pregnant and asked to have a therapeutic abortion done. She was afraid to have another child because a doctor in Germany had warned her that another pregnancy could be fatal. The doctor informed her that it would be much wiser, for her sake and the child's, to go on with this pregnancy as long as possible and at the right time he could do a Caesarean section.

Sometime later, she went to see the doctor again, reporting that she was passing a watery solution without any pains, after having a bad fall in the cannery.

MENTAL ATTITUDE

Normally, a mother during her prenatal period has many mental adjustments to make. In many cases there are worries such as financial and family problems, her own physical condition. Emotional instability, to a certain degree, accompanies each prenatal period and each patient must make adjustments to "face" her coming pregnancy.

Mrs. Rubens faced her delivery with fear and apprehension. She was discontented and had not adjusted herself to the customs and ways of this country. She did not have the same faith in the

Miss Furuya completed her training in 1951 at Royal Inland Hospital, Kamloops, B.C., and is now on the staff at the New Denver (B.C.) hospital.

doctors of Canada that she had had in the doctors in Germany. Also, she did not have a very extensive grasp of the English language.

Admission

On admission, Mrs. Rubens was very alarmed. Her membranes had already ruptured. She had indefinite pains about five to ten minutes apart but with no show. Her temperature was 102°, blood pressure 110/76, and the fetal heart rate was 120. Penicillin, 50,000 units every three hours, was started immediately as ordered.

The following morning she began to have definite pains with good contractions. There was some tenderness over the lower abdomen. At 8:00 a.m. her temperature was 97.2° by axilla and her pulse was slow and weak. She was perspiring around her face and her color was poor. There was some bright show. At 9:45 a.m. she was delivered of a stillborn male child. She was given ergotrate 2 ampoules for increased flow.

Her pulse became weak and her skin cold and clammy. A blood transfusion was started, with a cut-down at the femoral junction. Morphine sulfate gr. ¼ was given for restlessness. We were unable to get a blood pressure reading at 10:30 a.m. She was responding only periodically. Continuous oxygen, and an intravenous of glucose 10%, was started. At 1:30 p.m. her blood pressure was 65/42, her color had improved and her pulse was stronger. By 2:30 p.m. she had received 2,300 cc. of whole blood, 500 cc. plasma, and was getting continuous intravenous of glucose 10% in normal saline.

While receiving the second 500 cc. of blood, she complained of a severe backache. She was given morphine sulfate gr. ¼ but the backache persisted. After receiving 300 cc. of this blood, it was discontinued and a fresh bottle was started. The backache disappeared.

Mrs. Rubens was transferred to the isolation ward at 2:45 p.m., with her condition considerably improved. The placenta was still retained. The cord was cut and tied off at the vulva. There was no excessive vaginal flow and her blood pressure was normal. At 7:00 p.m. an abdominal pressure binder was applied because of increased vaginal bleeding. Her temperature was slightly elevated and she was perspiring freely. Streptomycin, gm. ½ twice daily, and penicillin, 50,000 units every three hours, were started to combat any possible sepsis.

The following day, her condition was slightly improved, but she was complaining of severe tenderness in the lower abdominal region, radiating to the back. She was given heroin gr. 1/12 for the pain. A vaginal pelvic examination was done by the doctor and a large blood clot was extracted.

Mrs. Rubens seemed to improve each day. Her blood pressure remained good, her temperature fluctuated from 99° to 101° but was gradually falling to normal. The sixth day, the cord from the placenta sloughed away. She was taking fluids well but refused any solid food. She was kept in a semi-Fowler's position and was encouraged to move and to take deep-breathing exercises to protect her from complications, such as hypostatic pneumonia.

A week later, Mrs. Rubens was able to get up, with assistance, and go to the bathroom. There was only slight vaginal discharge. At this point, the doctor decided she was well enough for surgery.

Wednesday, November 15, at 2:35 p.m., Mrs. Rubens was taken to the operating room. She was given seconal gr. 1½ and morphine sulfate gr. ¼, with atropine sulfate gr. 1/150 preoperatively. She returned from the operating room at 5:15 p.m., where she had had a subtotal hysterectomy performed. A continuous intravenous of 5% glucose and normal saline was running, her color was poor but her pulse was of fair quality. There was a moderate amount of vaginal bleeding. When she was conscious, she was given heroin gr. 1/6 for post-operative pain.

For the most part her recovery was uneventful but she was inclined to be lethargic and moved only with persuasion. As a consequence, she had considerable discomfort with flatulence. However, a week later she was able to be up and around.

Nursing Problems

Mrs. Rubens was familiar with many of the European languages, such as

Polish and German, with their dialects, but she had not yet learned to speak or understand the English language, except for a few words and broken phrases. This led to many problems in nursing care. Fortunately, during the critical stage, we had the aid of a student nurse who could speak and understand German. Later, in her post-partum period, we met with a few difficulties due to language differences, but one of the nurse aides was able to speak some German, though she was not always present. Mrs. Rubens needed constant reassurance about her condition. We tried to convey this by gestures and a few simple phrases. At first, I could not understand anything she was saying but, after the first few days, we were able to understand each other better. By listening very carefully I could understand a word here and there, which suggested a meaning. For example, she mentioned the word "glacier" and pointed to herself. I gathered that she was cold.

The main problem in the nursing care, then, was the language barrier. The patient was unaware of our language and customs as we were unaware of hers. This unawareness was largely responsible for her fear. She felt she was not able to make either the doctor or the nurses understand her history, her present symptoms, and her reactions.

Examination of the Uterus

The operation showed that the left broad ligament was very edematous, tapering off toward the pelvis. There were fine finger-like projections (villi) extending from a rent in the lower left segment of the uterus, toward the left broad ligament and the round ligament. The uterine veins were thrombosed by the uterine contents.

On examination, the uterus showed that the placenta was firmly attached to the posterior inferior wall of the uterus. The chorionic villi had grown into the uterine muscles. Therefore, this firmly implanted placenta could not be detached from the uterus.

Rupture of the Uterus

The rupture of a uterus is a very rare complication of pregnancy. In this condition, the uterus bursts because the strain is greater than the uterine muscles can withstand. It may occur in pregnancy or immediately after, as in this case. Most frequently, it occurs during labor. Most commonly, a rupture is due to a scar from a former Caesarean section or the injudicious use of pituitrin during labor.

A complete rupture occurs when it extends through the peritoneum; but in an incomplete rupture, only the body of the uterus is affected.

The severe shock Mrs. Rubens had suffered was probably due to the rupture of the uterus at a weakened portion of the uterine wall. The wall had been weakened, it was thought, by the manual extraction of placentae during previous deliveries, accompanied by the current placenta accreta. In her case, the peritoneum was not torn and the rupture must have occurred immediately after delivery, when the uterus contracted attempting to expel the placenta. The placenta, being firmly attached to the uterine wall, could not be expelled but, instead, it perforated the weakened portion in the lower segment of the uterus.

Our Debt to the Aged

The growing number of older people in our population has shocked us into concern for their well-being. A baby born 2,000 years ago in Rome had a life expectancy of 22 years, where today, in our country, a baby boy may expect to live 65.1 years and a girl 70.3 years. It is then no wonder that we need to understand the nature and the needs of our aging population. Medical science, which has contributed so much to lengthening the life span, cannot but accept some responsibility for the life thus prolonged. It is not a matter of making a person young again but an adjustment of health commensurate with his years.

B.C.G. Vaccination Program for Student Nurses in British Columbia

G. F. KINCADE, M.D.

THE POLICY of the Division of Tuberculosis Control in British Columbia is to provide protection against tuberculosis through vaccination of those not already infected. Although some aspects of the B.C.G. vaccination are still controversial it has been proven that the vaccine is harmless and that it does confer a considerable degree of protection against tuberculosis, even if it does not provide complete immunity. In view of the fact that the increased risk of tuberculosis among nurses and hospital employees had been well established, it was recognized that every possible protection must be given to this group in an endeavor to lessen the risk of infection. Although the usual educational and case-finding programs had been carried out, it seemed indicated, from the experience in other parts of the world, that further protection could be afforded through B.C.G. vaccination.

In 1947 the Division of Tuberculosis Control in British Columbia adopted the policy of B.C.G. vaccination for all known contacts of tuberculosis in the community and for hospital employees, particularly student nurses. Since that time practically all student nurses who were negative tuberculin reactors have been vaccinated on entering training and annually thereafter if they reverted to negative. It should be pointed out that all nurses in B.C. must have a five-week affiliation course in tuberculosis training before they write their registered nurses' examinations. Revaccination prior to affiliation in the tuberculosis course is particularly desirable so that no negative reactors will be exposed to tuberculosis during their course of affiliation.

Since the beginning of this program more than 2,000 student nurses having negative tuberculin tests were vaccinated. This represents almost 100 per cent consent for vaccination because it is rarely that a conscientious objector is encountered in this group. In the two larger schools, having a total, annual entry of over 300 student nurses a year, only two conscientious objectors have been encountered in a five-year period.

In carrying out this program it is essential that all student nurse applicants have a tuberculin test before entering training. The negative reactors are then vaccinated during their preliminary period and eight weeks later the tuberculin test is repeated. If still negative to the tuberculin test it is apparent that the vaccination has not been successful and this group is revaccinated. Almost 100 per cent convert to positive reactors in this way, over 90 per cent converting after the first vaccination.

The scarification method of vaccination is used and a pledget, moistened with B.C.G., is applied over the scratches. For convenience the site of vaccination has been on the front of the leg approximately six inches above the knee. This has proven very satisfactory. All B.C.G. vaccinations are performed by the staff of the Division of Tuberculosis Control.

INSTRUCTIONS TO SCHOOLS OF NURSING

In setting up the program it was decided that the schools of nursing should be responsible for administration, reading and recording of skin tests of students on entering the school and for annual retesting of the entire student body. The following instructions have been set forth by the Division of Tuberculosis Control for the nursing schools:

Preliminary students receive tuberculin tests during the preliminary term. B.C.G. vaccination is offered to those with negative tuberculin reactions. Tuberculin tests are repeated eight weeks after vaccination and the initial strength 1/10 mg. O.T. is followed by 1 mg. of O.T. if negative. For those who remain

Dr. Kincade is director, Division of Tuberculosis Control, Department of Health and Welfare, Province of British Columbia.

negative revaccination may be done immediately.

Follow-up tests in the schools: All students are retested with tuberculin annually and those who have converted to negative reactors are revaccinated.

Pre-affiliation tuberculin tests: So that all students taking tuberculosis affiliation courses will have positive tuberculin reactions, all students are given tuberculin tests three months before affiliation is due. The negative reactors are then revaccinated and will have the benefit of this vaccination being established before starting affiliation in a tuberculosis institution.

In the case of affiliates who have not been retested due to unexpected rotation changes in the home school, this is done on the first day of their affiliation and, if negative, they are followed closely by x-ray examinations. If the tuberculin test proves positive six weeks after affiliation students are again x-rayed.

Records: For the purpose of recording and follow-up, and for future study, a B.C.G. record card has been devised, giving the usual identifying information, together with date and frequency of tuberculin testing and B.C.G. vaccination, results of tuberculin tests and x-rays, and the results of follow-up examinations. This card is prepared in duplicate in the schools of nursing and on affiliation one copy is sent to the Division of Tuberculosis Control. If a student withdraws from a school without completing training the B.C.G. record is also sent to the Division of Tuberculosis Control where a permanent file on all B.C.G. tests is maintained. A sample of this record card is shown below.

In view of the relatively small number of student nurses vaccinated and the short period of time elapsed since the inception of the program one can only give impressions as to the effectiveness of the work. In British Columbia, tuberculosis among hospital employees has been a compensable illness since 1943. In reviewing the cases compensated for this disease by the Workmen's Compensation Board in the five-year period between 1944 and 1948, it was shown

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DEPARTMENT OF HEALTH AND WELFARE — T.B. 157
DIVISION OF TUBERCULOSIS CONTROL, VANCOUVER, B.C.

B.C.G. Record Card

Name .....
Home address .....
Age ..... Race ..... Occupation ..... Contact .....
Place of occupation
or school of nursing ..... Entry date .....
Pre-B.C.G. skin test ..... Date ..... Dose ..... Result .....
B.C.G. vaccination ..... Date ..... Type .....
Post-B.C.G. skin test ..... Date ..... Dose ..... Result .....
Revaccination ..... Date ..... Type .....
Post-B.C.G. skin test ..... Date ..... Dose ..... Result .....
Revaccination ..... Date ..... Type .....
Post-B.C.G. skin test ..... Date ..... Dose ..... Result .....

(reverse side of card)

Annual Skin Test			Annual X-Ray	
Date	Dose	Result	Date	Result

Date of affiliation ..... Skin tests on entry ..... ; Leaving ..... Six weeks .....

Recommendations for follow-up examination .....

Did T.B. ever develop? ..... Date ..... Record No. .....

that 65 student nurses had developed tuberculosis. From this it will be seen that during that period slightly over one case of tuberculosis developed each month in student nurses in this province.

Following the use of B.C.G. vaccination in student nurses there have been only four cases of tuberculosis in this group over a four-year period. Had the same rate of development prevailed as in the prevaccination era 50 cases would have been anticipated in this group. During that period there were no other changes in the program that would have any influence on the reduction of the tuberculosis hazard. There was no change in the case-finding program because the admission x-ray survey was operating to the same extent in both periods. The 44-hour week was effective throughout and the teaching and health supervision had not changed. In view of the fact that no other factors were apparent in this reduction of morbidity from tuberculosis in student nurses it would appear that B.C.G. vaccination is responsible for this marked reduction in the development of tuberculosis.

Very few complications of the vaccination have been noted. Through the use of the scarification method ulceration at the site of the vaccination has been almost entirely avoided. There were no general or constitutional signs or symptoms caused. The regional lymph glands, although always involved following B.C.G. vaccination, only in rare instances are palpable. We have no record of any cold abscess forming in the regional lymph glands. Occasionally the post-vaccinal tuberculin test will elicit a marked reaction but this has not proven of serious consequence.

In assessing the results in the prevention of tuberculosis among student nurses through the use of B.C.G.vaccination our studies have been limited by the fact that, following graduation, a considerable proportion of this group is lost track of since they move from the province or marry and change their names. However, from the short-term results, where the students can be followed closely while in training, it is obvious that a marked reduction in morbidity from tuberculosis has been achieved through the use of B.C.G. vaccination.

Anxiety —
A Factor in Nursing Care

Anxiety is a basic problem in nursing care and is described as being "vague, objectless and unspecific," as opposed to fear, which is reaction to a specific danger. In neurotic anxiety the reaction to the threat is out of proportion to the actual danger.

The nurse meets both fear and anxiety in her patient and should learn to recognize behavior that betrays a patient's underlying anxiety. She should be aware of the physiological reactions to anxiety—the perspiring hands, dilated pupils, changes in pulse and respiration, and restlessness. There are also camouflaged manifestations of anxiety which the patient cannot easily express. He may feel, if health is very important in his concept of himself, that illness is an indication of weakness and may mean failure or shame to him. Or if illness is a new experience to him, he may become anxious because he doesn't know what is expected of him, or because the behavior of the nurse does not meet his expectations and preconceptions.

The role of the nurse in helping a patient handle his anxiety constructively is without set rules and standard methods but there is no doubt that the person-to-person relationship of the patient with the nurse is one of the most important factors in the nursing care of the anxious patient. A satisfactory relationship prevents the patient being hampered by a judgmental, impatient or interfering environment.

There are a few general principles the nurse can use as guides. In the care of the anxious patient it is useful: to relate new experiences to the old familiar ones; to provide the patient with an opportunity to express his feelings; to give him the opportunity to work out his problems at his own pace; and to offer him unconditioned acceptance, without being critical, impatient, or judgmental.

—*American Journal of Nursing*, Nov, 1952.

Public Health Nursing

Providing Opportunities for Dynamic Learning

RUTH M. MORRISON, M.A.

IN NURSING education it has been traditional to use life situations through which to learn. Despite this, or perhaps because of it, there is danger that we may "rest on our laurels" and fail to keep up with general education in its newer concept of learning through experience. Classroom teaching, and much of the clinical teaching despite the use of living patients, has not always capitalized on the situation in such a way as to produce dynamic learning on the part of the nurse.

Cantor in his "Dynamics of Learning" (1: 11)* says, in discussing his method: "The question of whether or not this approach is equally valid for all courses of the liberal arts college (and even technical and professional schools) is an open one. The answer would depend on finding out in what areas it can be most effectively used . . ." His method is essentially in agreement with Hopkins (5:260-269) and, in regard to this, Muse in her "Guiding Learning Experience"(6:549)adapts his specifications for cooperative planning and adds:

> Hopkins does not include knowledge of desired outcomes which, of course, lacks significance in elementary education; but the conclusion of the Joint Committee on Nursing Education is that this is imperative for effective preplanning at an adult level. Certainly in nursing education as clear as possible an understanding of ultimate goals and of desired directional progress is equally imperative.

*The first number in brackets indicates position in the bibliography, the second denotes the page.

Miss Morrison is assistant professor in public health nursing at the School of Nursing, University of British Columbia, Vancouver.

While it is true that nursing students have specific skills to learn and, therefore, have to that extent definite goals or "fixed ends," which are set in advance by the teacher, nevertheless I believe that in most parts of their education there is much scope in which to permit opportunities to develop "operational unity, integration and a more adequate self" as Hopkins has suggested.

During the public health field experience of nursing students, then, Hopkins' criterion of "unfixed ends" should to a limited degree be possible. The remaining criteria which he cites as essential to the process of deliberative action may be summed up as follows: that opportunities should be created for students and teacher to work together; that both must concentrate on process rather than knowledge sequence; that the teacher must allow freedom of self-selection by the students and be willing, therefore, to change the entire subject matter; and that, by reviewing

RUTH M. MORRISON

the process, the students have opportunity to make qualitative judgment of their own work.

University schools of nursing endeavor to organize the field training secured in a generalized public health nursing service so as to permit dynamic learning for each of their students. I am concerned with the consideration of how the planning for this experience may improve the chances of these criteria being met. It seems to me that it is the people concerned with planning and organizing this experience (and this includes the student) rather than the physical set-up or the sequence of events that will determine how successfully integrated dynamic learning will take place. Because of this opinion I will consider particularly those immediately involved in such planning and attempt to show their importance in the field training situation.

Public health agencies exist to give health service to the community in accordance with its needs. They do not exist primarily for the education of public health personnel though this must be one of their objectives and purposes if there is to be a stock of well prepared personnel from which to recruit future employees.

Also any modern public health agency which genuinely desires to give the best public service and retain good workers must recognize the need for continuous staff education. If this is the case a well qualified educational consultant is an essential part of the staff.

In nursing, more than in some professions, it has been traditional for the graduate to assist in training the undergraduate and the older nurse to help the younger. True, we have been struggling to overcome the handicaps of the apprentice method of learning in nursing but it has some features which, I believe, we should and will retain and build upon, rather than completely discard. This sense of responsibility for sharing in the education of beginning public health nurses is one of the features that falls into this class and, by the use of field guides working under the direction of the supervisors and the educational consultant, this idea has been exemplified. It coincides with the criterion which Hopkins has established—that opportunities should be created for teacher and student to work together. If dynamic learning is to result this working together must not be merely a sharing of labor in the practice field but rather a working together to make each experience a process of development for both student and field guide, particularly for the student.

This brings me to the criterion of concentrating on process rather than knowledge sequence. The temptation to estimate how much has been taught or learned in terms of skills acquired or facts learned is great. As has already been indicated the student of public health nursing must learn certain skills during her field training but the emphasis can be shifted from techniques to the development of attitudes, value judgments, and deliberative actions by using the learning of the technical skill as a means rather than an end. If this type of learning is to take place the student must have been guided into the habit of qualitative learning before she arrives in the field. She must see it happening to others in the field. She must have a field guide who is convinced of its importance and capable of permitting it to happen. This means that the university instructors, the educational consultant, and the supervisors in the agency must help the field guides to develop teaching ability. Freeman (2:324-328) and Gilbert (3:529-530) both offer concrete suggestions as to how this may be done.

There should be agreement reached by the university faculty members as to when, where and how the field experience will be provided and one instructor made responsible for arranging it for a given student.

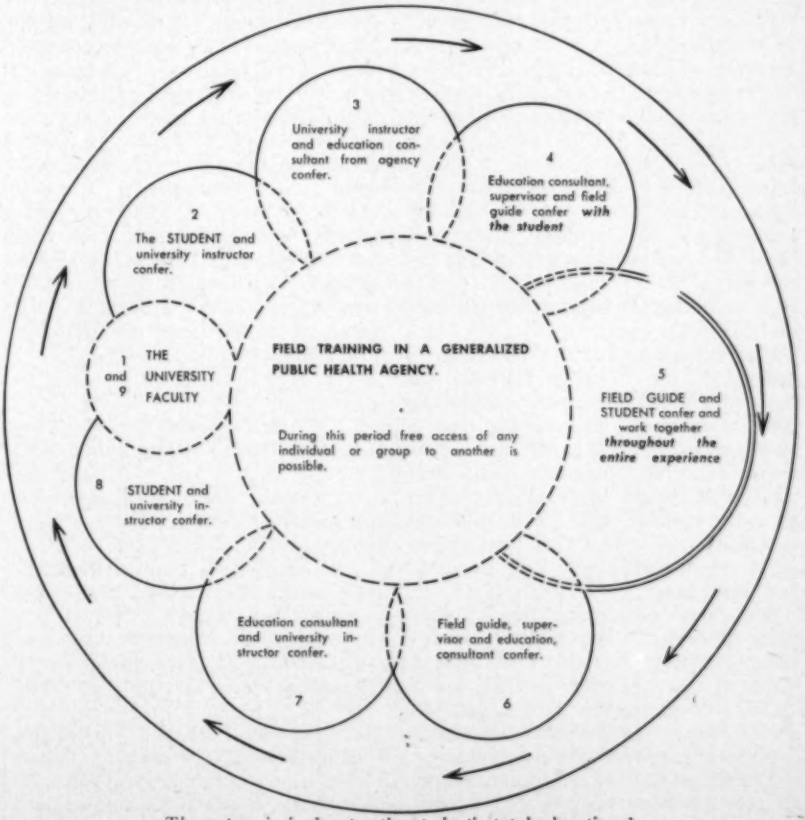
Before the student leaves the school to go to the agency the instructor and she should confer regarding her special needs and interests. This should be followed by a conference between the instructor and the educational consultant from the agency when these needs and interests, together with other pertinent data such as personality traits, academic ability, and biographical information, can be discussed. The educational consultant will then have a better basis for selecting the unit for placement and

the field guide best suited to meet the students' needs.

If possible the educational consultant should be a part-time faculty member. She and the full-time faculty members should work closely throughout the year. Even if she is not an official member of the faculty the relationship can be very close. In actual practice the field work planning can be much less formal than the following might seem to indicate.

When the student arrives in the field agency, she requires an orientation to the agency. At the end of this period and in the light of previous learning in connection with classes, laboratories, clinics, nursery schools, hospitals and other agencies, she should have a fair idea of the experiences that this agency can provide for her that will supplement and enrich the background which she brings with her to this new situation. If a conference can be arranged for the student, the field guide, supervisor, and consultant, in which the student may discuss with her new teachers what she feels her needs to be in relation to what the agency has to offer, it should pave the way for freedom of self-selection by the student and a willingness by the field guide to change subject matter as required which, it will be remembered, is another criterion of Hopkins for education through experience.

If it is not possible, because of a large number of students beginning field training on the same day, to arrange conferences such as I have described it should usually be possible to have a


3
University instructor and education consultant from agency confer.
4
Education consultant, supervisor and field guide confer with the student
2
The STUDENT and university instructor confer.
1 and 9 THE UNIVERSITY FACULTY
FIELD TRAINING IN A GENERALIZED PUBLIC HEALTH AGENCY.
During this period free access of any individual or group to another is possible.
5
FIELD GUIDE and STUDENT confer and work together throughout the entire experience
8
STUDENT and university instructor confer.
Education consultant and university instructor confer.
7
Field guide, supervisor and education, consultant confer.
6

The outer circle denotes the student's total educational experience of which field training is a part.

group of students in the same unit meet jointly with their field guides, supervisor and consultant, followed by individual conferences for each student with her guide. There should be conferences at intervals during the student's experience with the agency between the field guide and the supervisor, the supervisor and the educational consultant, and sometimes all three. The student should be included when indicated—that is, if there is anything to be gained by her presence. Frequently, however, the problems to be discussed will be those which are concerned with the development of the field guide in her supervisory capacity and the student's presence might hinder rather than enhance the discussion.

Probably the area of greatest weakness in field learning is in the evaluation process. If student and guide are constantly exchanging ideas, working together on process rather than knowledge alone, and the student has learned through her own selection of experiences, evaluation will have gone along step by step and a final self-evaluation in terms of qualitative judgment of her own work (in both oral and written form), through discussion with her field guide, will result in a genuine understanding, on the part of the student, of her accomplishments and her failures, her strengths and her weaknesses.

The written and oral evaluation report which the consultant brings to the university should be a composite of all these discussions and a further discussion between the field guide, her supervisor, and the educational consultant. The result should be dynamic learning by both student and guide, and the university should be just as interested in the developmental learning of the guide as is her agency.

The final conference which takes place between the student and her instructor at the university should present opportunities for further self-evaluation by the student and for the instructor to share with her colleagues suggestions for improvement in the curriculum.

The accompanying diagram attempts to show the relationship of the student's field training to her total educational experience, the persons directly involved in providing a dynamic learning experience, and their relationships to the student and to one another.

Some field guides, particularly more senior personnel, may at first find it very difficult to permit students to assume much of the responsibility for their own growth and some students may not have developed sufficient skill in handling their own learning experiences in a mature fashion. However, all experimentation involves some risk. Traditional teaching has so often failed to develop potentialities in those who could have grown the most. In the long run less risk is involved than at first appears if sufficient understanding is generated during the conferences. Our *best* clinical teachers and field guides *have* used methods which meet Hopkins criteria and fit well into Cantor's patterns of teaching for dynamic learning. Their greatest hindrances have been that the students have not been sufficiently exposed to this type of educational climate; hence the need for organizing the field training situation so that the greatest learning may take place even if some risk is involved.

Plato's thesis is that to arrange people's experience so that they may learn as much as possible *is the essence of democracy*. Lyman Bryson has said that the real reason for the renowned greatness of the Greeks is that "they believed in learning."

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Children's Behavior

If parents understand the unconscious character of their child's behavior they will be better able to deal with the problems created by that behavior. Habits such as thumb-sucking, nail-biting, enuresis, temper tantrums, and stubbornness appear much less alarming than most parents consider them. These habits represent sensory and emotional satisfactions at the thalamic level and, although the child may be intellectually aware that they are considered undesirable, they are in themselves pleasurable and generally not physiologically destructive. Indeed the satisfactions are frequently so great that scolding, deprivations, and even severe whippings fail to cause the child to give up his habits.

Our problem is one of learning how much of the behavior is purposeful and how much is unconscious. Once the motivation behind a habit is discovered, situations must be created in which the child will be motivated toward control of the undesired habit pattern.

If the parent understands that the child's behavior has satisfying unconscious meaningfulness he can frequently use his experience and ingenuity to make it worthwhile for the child to change an objectionable habit. The case of temper tantrums illustrates this principle. In such a situation the parent should employ the technique of quiet isolation; this puts the decision up to the child as to how soon he will change his response from that of temper outbursts to one more appropriate to the social circumstance.

Isolation is an effective technique provided that it is carried out not as punishment for misbehavior but rather in order to create circumstances that put the decision up to the child. Another technique is that of using the concept of "babyishness" rather than "badness." A child may be persuaded away from babyishness if the behavior is actually presented as such. The avoidance of diminutive names also serves to encourage mature behavior. Another technique which often accomplishes wonders is that of giving the young child a real sense of participation and feeling of the worthwhileness of his own opinion in the family circle.

—Dr. F. N. Anderson

Foreign material in the eyes is probably the most common complaint of those seeking medical advice because of an acute eye condition. Small foreign bodies frequently lodge somewhere in the conjunctival sac or in the cornea. When this occurs the predominant symptom is pain or a scratchy sensation in the eye, the severity of the symptoms depending upon the location of the foreign body. In searching for such foreign bodies a good light is essential and the simplest is that produced by an ordinary condensing lens which will focus the light from an incandescent lamp on the eye. If the foreign body is found either on the upper or lower palpebral conjunctiva, or on the bulbar conjunctiva, it can usually be removed very easily with a toothpick swab. In the case of conjunctival foreign bodies generally no anesthetic is necessary. However, if the object has become embedded in the cornea a local anesthetic is necessary before removal is attempted. For this I have found a ½% solution of pontocaine hydrochloride to be ideal, three drops being instilled at intervals of about 30 seconds. A corneal foreign body should never be removed or an attempt made at removal with a cotton swab. This only denudes the cornea of a portion of its epithelium and tends to push the foreign body deeper into the corneal stroma. A 22-gauge intravenous needle attached to a syringe for a handle will serve very well. The needle should be inserted just to one side of the foreign body and then worked below it. In this way the foreign body can be lifted out with a minimum of corneal damage.

—Dr. W. P. McGuire

Institutional Nursing

The Board of Trustees and the Matron

JUDGE J. M. GEORGE

THE RESPONSIBILITIES of a hospital trustee are large, and so are those of a matron. The largest responsibility of both, however, is to understand the role of the other. Many of the differences that arise between a trustee board and its matron are the result of lack of knowledge and understanding of the duties, responsibilities, and rights of each other. Until these are thoroughly known and understood, there cannot be the complete teamwork that is necessary for the successful administration of the hospital.

Too many Boards of Trustees feel that when they have engaged a registered nurse as matron of the hospital, their responsibilities for administration of the hospital cease. They fail to recognize the fact that, although their new matron has received her R.N. and is, therefore, fully qualified to fulfil her duties as a nurse, they may never have inquired into her qualification for administering the services of the whole hospital. They may place a person in a position of responsibility for which she has had no special training or knowledge and leave her to work out her own salvation without much help or guidance. In that way they are expecting more of her than she should be expected to give. They immediately place her under a handicap and very often in an unenviable position.

The Board must know what the duties and responsibilities of a nursing matron are before they can say what they expect of her. One of the main duties of the Hospital Association is to see that those who govern a hospital know something of the intricacies of hospital administration. Speaking as a trustee, I wonder if I have sufficient knowledge of hospital administration to speak authoritatively on what a Board should expect of a matron. Yet I welcome the opportunity of expressing my views on the subject in order that I may be put right on any wrong opinions I may express and hereafter be more qualified to fulfil the duties of trusteeship.

In this discussion we are thinking of small rural hospitals. Such hospitals are in the unfortunate position of not being able to engage professional administrators and have to rely on trained nurses as superintendents. Furthermore, most of these hospitals have to rely on nurses who have not had the opportunity of taking a course in hospital administration, and who are dependent entirely on such knowledge as they may have gained while taking their training or in subsequent staff work. In many instances, therefore, we have a team made up of boards and superintendents wandering around in the dark, each wondering which way they should go.

Naturally, when anyone engages an employee, they expect him to have the qualifications for the job for which he is engaged. This also applies to a hospital board engaging a matron. If they are careful in their selection, they should at least expect good supervision of all nursing services.

Nursing supervision, however, is only a part of the duties of a matron. By virtue of her position as executive director of the hospital and as deputy of the Board of Trustees, she has the responsibility of carrying out the policy laid down by the Board for the administration of the hospital. She must direct and manage the general activities and functions of the hospital so that it will be able to achieve its objective of service to the sick with efficiency, economy, and satisfaction.

It should be the aim of the matron that her hospital will enjoy the fullest

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Judge George is president of the Associated Hospitals of Manitoba.

confidence of the public, will have the sympathetic support of the community, will warrant the loyalty and trust of all allied professions, will constantly link itself with scientific advances, and will take its rightful place as a leader among the health forces of the community.

The matron should at all times be courteous and considerate in dealing with both patients and relatives. Firmness in financial matters should be no more than is amply justified by the circumstances of the case.

Particularly, the matron will observe respect for professional secrecy and confidence in dealing with the sick. Moreover, this essential principle should be impressed by the matron upon all who deal with confidential records or have access to other information.

The matron should endeavor to meet the legitimate requests of her patients with respect to comfort and general care, opportunities for observance of religious customs, protection from noise, unwelcome visitors or other factors that interfere with recovery.

All of the above requisites she should be able to fulfil as the result of her nursing training.

There are, however, many other duties which she will be expected to perform and which, without special training in administration or by extensive practical experience, she should not be expected to perform, with full efficiency, until that experience has been gained. These include personnel management—the engaging and dismissal of not only professional but also non-professional staff—the supervision of other branches of hospital service apart from nursing service, and the purchase of supplies for all departments.

As nursing service is the most important branch of hospital service and, therefore, demands the closest supervision and the greatest part of the matron's time, too much should not be demanded of her in the other branches of the service. Competent and trained personnel in direct charge of other departments—such as dietary, laundry, and business office—should be the objective of the Board, so that the responsibility of the matron may be limited to general supervision of these departments, rather than having to be worried with the details of their operation. She should be relieved, as far as possible, of general business management of her hospital other than the responsibility of seeing that those thus employed are capable of the duties they undertake and fulfil those duties to the best of their ability.

In these latter duties she should have the full cooperation of the Board by being made fully acquainted with the by-laws of the hospital and the policies developed from time to time. This can only be done by the closest collaboration between the matron and the Board. She should keep her Board fully informed as to progress made in the course of her administration and refer to it such problems for consideration as may appear to be beyond her ability to solve in an amicable manner. She should also be permitted to suggest to the Board any changes or improvements that, in her opinion, would be in the best interests of the hospital. To perform these functions, she should be given the opportunity of meeting with the Board as frequently as she may deem necessary. Such meetings should be given every possible encouragement.

In her executive capacity, as deputy of the trustees of the hospital, the matron's attitude toward the trustees should be respectful at all times, refraining from partiality and from any violation of their confidence.

The relationship of the matron to the medical staff should be one of sympathetic understanding and helpful cooperation. She should endeavor to have medical problems adjusted by the medical staff. If necessity arises, however, the matron, as the representative of the Board of Trustees, must act with decision and firmness, consistent with the welfare of the patients and the continued good reputation of the hospital.

The matron should recognize that the establishment and maintenance of satisfactory relations with employees is necessary, not only in justice but also to secure the effective utilization of the abilities and services of the individuals of whom hospital organizations are composed. To this end she should extend the consideration which is the

right of all conscientious and loyal workers. At all times she should be impartial, tolerant, and fair in her relationships.

Visitors should be treated with courtesy and their inquiries should merit every consideration. If firmness toward them should be required, such should be exercised with judgment, tact, and the mininum of embarrassment for them and the patient. It should be borne in mind that the welfare of the patient is the primary concern of the hospital, and the thoughtlessness, selfishness or inquisitiveness of visitors should never be permitted to interfere with the patient's recovery or provide information to which outsiders are not entitled.

The matron should always strive to keep in close touch with community activities, with community progress, and particularly with community needs. She should cultivate reasonable opportunities for favorable public contact, provided such activity does not interfere with her primary responsibility—the performance of her administrative duties. The matron must realize that no action of hers, whether while on duty or off, can be entirely divorced from the reputation of the institution with which she is concerned.

All of this may seem like a large order. To enable her to fulfil all of these duties efficiently, the Board of Trustees should be able to give the matron every opportunity of extending her knowledge of hospital administration through short courses, attending hospital conventions and institutes, without too greatly prejudicing the economy and operation of the hospital.

Dr. W. G. Penfield, O. M.

Nurses in all parts of Canada will share in the pride of the Montreal Neurological Institute over the award of the Order of Merit to Dr. Wilder Graves Penfield in the Queen's New Year's honor list. Director of the Institute since it was opened in 1934, Dr. Penfield received the award of this, the highest civil decoration in the Commonwealth, in recognition of his services to humanity as one of the leading neurosurgeons of the world.

The honor conferred on Dr. Penfield was designed as an Order of special distinction for eminent men and women. Limited to 24 persons at any one time, Dr. Penfield is believed to be the second Canadian to receive it. The badge of the Order, worn around the neck, consists of a cross of red and blue enamel bearing the words "for merit" in letters of gold. The whole is surmounted by an imperial crown suspended by a ribbon of garter blue and crimson two inches wide.

Moving Day Soon

Those of you who have honored us with a visit during the past year or two will recall the congestion in our offices that has resulted from our steady growth. When we moved to our present place in 1944, our staff of four had ample room. Today, with double that staff and much more equipment, we find ourselves exceedingly cramped.

New accommodation has been found in a very convenient location. Right next door to the office building where we have been so long, is a private residence that has been converted into offices. There you will find us on the second floor. A hearty welcome awaits all visitors.

As of MARCH 1, 1953, the address of *The Canadian Nurse will be:*

1522 Sherbrooke Street, West,
Montreal 25, Quebec.

Aux Infirmières Canadiennes-Françaises

Le Nursing du Prématuré

Z. OPPLIGER

Note de la Rédaction: Même si les méthodes employées en Belgique diffèrent quelque peu de celles employées au Canada, les principes à la base des soins sont les mêmes. Nous n'avons voulu rien omettre de cet intéressant article, laissant à chacune le soin de remplacer par des méthodes qui nous sont propres celles données ici.

* * *

TOUTE FUTURE MERE devrait être examinée et dirigée par un médecin, par une accoucheuse, ou suivre une consultation prénatale de l'Oeuvre Nationale de l'Enfance et cela durant toute la grossesse.

L'infirmière d'hygiène sociale, attachée à une consultation, a pour rôle d'inculquer les règles d'hygiène, de recommander repos et ménagement, surtout vers le septième mois. Elle doit pouvoir résoudre les nombreux problèmes que la future mère lui expose, veiller à ce qu'elle prenne le repos obligatoire si elle travaille en dehors de son foyer. Si une mère de famille nombreuse risque de se surmener, l'infirmière doit lui procurer une aide ménagère. Si la future mère est abandonnée et sans ressources, l'infirmière la placera dans une maison maternelle.

Devant une menace d'accouchement prématuré, l'infirmière, ou l'accoucheuse, a le droit et le devoir, tant que la poche des eaux est intacte surtout, d'exiger le repos au lit; de prévenir d'urgence la médecin et, en l'attendant, de donner à la femme, soit 2 x 20 gouttes de laudanum per os, ou par petit lavement à intervalle de quelques heures, soit de lui mettre un suppositoire de morphine si le médecin l'autorise.

Bien souvent le médecin parvient à arrêter ce début de travail et la grossesse a des chances à continuer son cours si la femme prend du repos et se ménage.

Pour bien comprendre les soins dont les prématurés sont l'objet, il est nécessaire de rappeler brièvement ici, les principaux caractères physiologiques de ces enfants.

CARACTERES PHYSIOLOGIQUES DES PREMATURES

Appareil respiratoire: Le centre respiratoire bulbaire du prématuré n'est pas arrivé à maturité. Ceci explique sa respiration superficielle, insuffisante, les fréquentes crises de cyanose dont il risque d'être victime. On explique celle-ci de la manière suivante: l'enfant cyanosé, manquant d'oxygène, respire d'une manière accélérée. Au fur et à mesure qu'il s'enrichit en oxygène, sa cyanose disparaît. A un moment, son sang est tellement riche en cet élément que son centre respiratoire devient hypo-excitable—une petite quantité d'anhydride carbonique est en effet nécessaire pour stimuler le centre respiratoire bulbaire. L'enfant se met doucement en apnée, asphyxie et se recyanose. Ainsi de suite. Notons dès à présent que la répétition de tels accès est d'un pronostic défavorable.

Appareil digestif: (1) L'insuffisance du développement du système musculaire des joues rend la succion difficile ou impossible; (2) souvent, le réflexe de déglutition n'existe pas et le prématuré "avale de travers" donc grand danger de pneumonie de déglutition; (3) la fonction digestive est généralement incomplète et, par conséquent, le prématuré est très difficile à alimenter et

Reproduit de *l'Infirmière* (oct. 1952), organe de la Fédération Nationale des Infirmières Belges. *L'Infirmière* doit cet article à l'obligeance de l'Oeuvre Nationale de l'Enfance. Mlle Oppliger est monitrice de la Maternité Universitaire de l'Hôpital St-Pierre, Bruxelles.

à nourrir. De grands dangers d'entérite le menacent.

Chez le prématuré, il existe une disproportion entre le revêtement cutané (trop grand) et la masse centrale des tissus (trop petite). Par conséquent, il a une forte déperdition de chaleur: l'hypothermie est fréquente. La régulation thermique ou *thermo-régulation* ne s'installe que lentement. Inversément, sous l'action de la température ambiante, le prématuré peut présenter des "coups de chaleur" très élevés, son mécanisme physiologique de refroidissement ne fonctionnant pas ou trop tardivement. De plus, l'absence du panicule adipeux favorise également la déperdition rapide de la chaleur.

Peau: Elle est très fragile et le prématuré risque de présenter de l'intertrigo, des érythèmes.

Le *sclérène*—qui est une solidification pathologique de la graisse, du tissu cellulaire sous-cutané, sous l'influence du froid—est, comme les accès fréquents de cyanose, de mauvais pronostic, s'il est fort prononcé.

De tout ceci, il ressort qu'il faudra:

1. Lutter contre le refroidissement.
2. Lutter contre l'infection.
3. Alimenter et nourrir correctement.
4. Observer une hygiène générale stricte:
   en ce qui concerne l'enfant;
   en ce qui concerne le personnel soignant:
   les objets, locaux, matériel de soignage.

Soins a Donner aux Prematures a leur Naissance et Immediatement Apres

Soins à donner à une parturiente en travail, non à terme: Les soins généraux sont pratiqués comme pour toute parturiente. Les bruits du cœur fœtal sont strictement surveillés. S'ils s'altèrent, le traitement classique par masque à O_2 et coramine I. V. appliqué à la mère, donne, la plupart du temps, de bons résultats. Certains accoucheurs préconisent l'injection préventivement de la vitamine K durant le travail pour éviter les hémorragies chez le fœtus.

En surveillant le travail de la parturiente, l'accoucheuse aura pris connaissance des renseignements fournis par celle-ci et par la fiche de la consultation prénatale. Il est nécessaire de savoir pourquoi la mère accouche avant terme. Il importe de connaître son état moral, mental, ainsi que ses conditions de vie matérielle et d'hygiène.

Si c'est une primipare, il faut examiner les seins, voir si les mamelons sont bien formés, si le réseau veineux est apparent et si l'état général de la femme permettra la lactation.

Si c'est une multipare, il convient de s'enquérir si elle a bien nourri les enfants précédents. Ceci nous aidera à juger les chances de l'allaitement maternel.

Suivant l'âge de la grossesse et en voyant le volume de l'abdomen après la rupture de la poche des eaux, nous pourrons déjà présumer du poids de l'enfant.

Dans notre service, la répartition des prématurés se fait dans l'ordre suivant:

1. En dessous de 1,800 gm., le prématuré est mis en isolette.
2. De 1,800 à 2,400 gm., le prématuré est mis dans la chambre couveuse (chambre couveuse à conditionnement d'air et ayant plusieurs boxes).
3. Un prématuré de huit mois, ayant un poids entre 2,200 et 2,400 gm. *criant bien* à la naissance, présentant une bonne coloration, né de *mère bien portante*, future bonne nourrice et de bonne condition sociale est mis en chambre avec sa maman. En prolongeant quelque peu son séjour, la maman quittera la maternité avec son bébé.

Soins donnés aux prématurés de ces diverses catégories: Quand la maman est en travail, que l'on sait l'âge de la grossesse et que le bébé est destiné à être placé en isolette, celle-ci est mise en ordre de marche—deux heures sont nécessaires pour obtenir la température de 36°C.

A la chambre couveuse, un berceau sera chauffé d'avance au cas où le bébé est plus gros que prévu. L'accoucheuse veillera à la bonne température de la salle d'accouchement et de la nursery: 26°C. Dès la dilatation complète, le ressuscitator sera mis en état de marche. Il y aura aussi une grande alèze stérile chauffée d'avance ainsi que des langes molletonnés, stériles, chauffés. L'huile sera tiède, instruments, seringues—tout sera prêt pour l'arrivée du prématuré.

LE NURSING DU PRÉMATURÉ

Soins au prématuré, né en bonne condition, allant en isolette: Pour bien conduire un accouchement prématuré, il faut, si possible, disposer de deux accoucheuses ou infirmières accoucheuses—l'une aidant l'obstétricien et l'autre s'occupant uniquement du prématuré. Cette dernière, dès la période d'expulsion, mettra un tablier en caoutchouc désinfecté, un masque en gaze stérile, et elle se désinfectera soigneusement les mains.

Dès que la tête apparaît, l'accoucheuse prendra l'alèze stérile et chauffée et l'accoucheur y déposera doucement le nouveau-né en position horizontale. L'enfant est entouré de l'alèze chauffée. La section du cordon est opérée quelques minutes après la naissance pour que l'enfant récupère le plus de sang possible. Le prématuré est ensuite transporté à la nursery et déposé dans le ressuscitator chauffé. Le prématuré crie, la coloration et les mouvements son normaux. Voici les soins qui lui seront donnés:

1. Rapidement, soins des yeux, suivis d'instillation de nitrate d'argent frais à 1½%. Une goutte dans chaque oeil.
2. Soins et ligature du cordon, pose du bracelet d'identité au poignet. Puis transport immédiat dans l'isolette.
3. Faire la piqûre de vitamine K.
4. Toilette sommaire à l'huile tiède pour enlever sang et glaires, contenant des microbes qui risquent d'infecter l'enfant.
5. Pesée du prématuré.

Le prématuré sera couché sur le dos, le thorax et les épaules légèrement surélevés par un coussinet d'ouate stérile. La tête tournée soit à droite ou à gauche. Cette position facilite la respiration et l'évacuation des glaires. Le débit d'oxygène sera réglé à 2 à 4 litres par minute dès que le prématuré est dans l'isolette.

L'infirmière surveillera de près, jour et nuit, son comportement, sa respiration, sa coloration, ses mouvements. Les mictions et les selles seront notées. Ceci vaut pour les premières 24 heures.

Soins donnés au prématuré né en état d'asphyxie bleue ou blanche: Dès que le cordon est sectionné, le prématuré est placé, bien couvert par l'alèze chauffée, dans le ressuscitator. En premier lieu, les mucosités sont extraites à l'aide de l'aspirateur électrique dont l'intensité est réglée d'avance. Pour ce faire, nous employons une sonde en caoutchouc no 10, à orifice médian. (Après chaque usage, les sondes seront stérilisées.)

Cette manœuvre doit être accomplie avec beaucoup de douceur. Dès que les mucosités sont enlevées, on administre de l'oxygène par insufflation, le débit est réglé à 4 litres/minute. L'oxygène se donne par intermittence. (Après usage, le masque à oxygène est désinfecté avec une solution de désogène à 5%.) Sur ordre médical, de petites doses de caféine ou coramine intramusculaire sont administrées.

Quand le prématuré respire bien, que sa coloration devient normale, on le transporte rapidement, bien couvert, dans l'isolette, milieu idéal pour lui au point de vue conditionnement d'air et chaleur. Les prématurés, demandant des soins d'urgence, ne recevront les soins normaux requis pour tout nouveau-né que dans l'isolette (soins des yeux, soins du cordon, vitamine K, pesage).

Le prématuré qui a été réanimé doit être surveillé de très près. En général, s'il gémit, c'est mauvais signe, il peut faire une hémorragie méningée. Les soins, dans ces cas, seront réduits au strict minimum pendant les premiers jours.

Remarque: Pour les accouchements pratiqués *sous narcose*, la section du cordon se fait dès la naissance de l'enfant, pour éviter le passage des produits toxiques dans la circulation fœtale. Dans ce cas, l'enfant naît parfois légèrement endormi. Sa respiration et coloration sont normales mais il ne crie pas. Il suffit de le mettre dans le ressuscitator, de faire quelques aspirations et de donner de l'oxygène. Il crie après quelques minutes.

(*La suite au prochain numéro*)

No evidence has been found to support the theory which is occasionally stated that the pigmentation of the dark races is due to pigment not normally found in the white, or to an increase of the ordinary pigments other than melanin.—C. M. MacBryde, M.D.

Nursing Profiles

Beatrice Pearce Cassidy has brought broad knowledge and experience in public health and social welfare to her new duties as secretary of the Health Division, Toronto Welfare Council. A graduate of the Vancouver General Hospital, Mrs. Cassidy holds her B.A.Sc. (nursing) from the University of British Columbia. Staff work with the Victorian Order of Nurses in Victoria, prior to her marriage, was a prelude to later work as assistant educational director, then supervisor with the Instructive Visiting Nurse Society in Washington, D.C. She worked for a time on the staff of the Children's Aid Society in Toronto. During World War II, she engaged in industrial nursing. In between the periods of active duty Mrs. Cassidy has been busy on boards and committees of various welfare organizations. Thus she is very familiar with all of the aspects of community health service. Her present work will be concerned with the coordination of the various agencies, both official and private, that are sponsoring health programs in the Greater Toronto area. With all this activity, plus caring for her children, Mrs. Cassidy's summer is complete when she can get out on the courts for tennis.

Milne, Toronto

BEATRICE P. CASSIDY

Clara Roper Aitkenhead has assumed her duties as director of nursing of the Sherbrooke (Que.) Hospital. Born in Scotland, Miss Aitkenhead is a graduate from The Montreal General Hospital and, in teaching and supervision, from the McGill School for Graduate Nurses. Her first position was as head nurse, later night supervisor at the Shriners' Hospital in Montreal. When she turned to teaching, Miss Aitkenhead went to the Queen Elizabeth Hospital, Montreal. After eight years there as nursing arts instructor and health counsellor, she returned to her own hospital as head nurse in the medical department. Until her recent appointment she had been the instructor in nursing care of communicable diseases at Alexandra Hospital, Montreal.

Professional activities have claimed a large share of Miss Aitkenhead's time and interest. She has been chairman of the Instructors' Group, A.N.P.Q., a member of the Board of Examiners for ten years, and has held office in both of her alumnae associations. With all of this, she has found time to become exceedingly proficient in dressmaking and smocking, to develop a considerable library of her own films, and to carry on an extensive personal correspondence. At the moment, her greatest joy is her electric cake-mixer!

Van der AA Portrait Studio, Montreal

CLARA AITKENHEAD

Myra Pearson returned to the school from which she graduated—the Dauphin (Man.) General Hospital—to assume the duties of lady superintendent. For the past two years Miss Pearson was director of nursing at the Clearwater Lake Sanatorium at The Pas.

Margaret Louise Peart is the new director of nursing at the General Hospital, Belleville, Ont. A graduate of St. Joseph's Hospital, Hamilton, Ont., Miss Peart secured her certificate in nursing education from the University of Toronto School of Nursing, then returned to her own school as nursing arts instructor. Two years later she joined the Outpost Hospital Division of the Ontario Red Cross Society. The four years spent as nurse-in-charge of small hospitals in Northern Ontario has given Miss Peart an excellent background of administrative experience for the new work she has undertaken.

In Memoriam

Agnes Bulloch, who graduated from the Montreal General Hospital in 1895, died recently in Montreal.

* * *

Pearl Craigie, who graduated from the Ottawa Civic Hospital in 1930, died in Ottawa in July, 1952. Miss Craigie had been active in private nursing and in general staff work in a convalescent hospital in Ottawa.

* * *

Dorothy Phillips, who graduated from the Glace Bay General Hospital, N.S., in 1950, died at the age of 23 on November 22, 1952, as the result of injuries suffered in a motor accident near Moncton, N.B. Soon after graduation Miss Phillips joined the T.C.A. as stewardess.

* * *

Margaret Roddan, who graduated from Royal Columbian Hospital, New Westminster, B.C., in 1948, died at the age of 31 on November 10, 1952, following a lengthy illness. Miss Roddan took an active part in the organization of the Student Nurses' Association of B.C. and was its first president. Following graduation she worked for a time at the White Horse (Y.T.) General Hospital.

In the Good Old Days

(*The Canadian Nurse*—FEBRUARY 1913)

"IF THE RECORDS OF medical inspection in any school be examined it will be found that the great bulk of the physical defects are in the mouth, the results of examinations in most localities showing an average of about 95 per cent of children with defective teeth . . . Toronto is about to establish a dental hospital for children, the first municipality in Canada to recognize this need."

* * *

"Believing that there is no more direct and potent agency than the teacher in shaping the standards and ideals in the work of the young nurse, we feel that every training school worthy the name should have its expert teaching staff trained for this special work. Without a sound system of teaching in both principles and practice of nursing there can be no genuine progress: there must, indeed, be retrogression."

* * *

"The nurse with only hospital training is unable to cope with the situations presented in the new field of public health nursing . . . The ability to present instruction to patients and families in a way that will be understood and accepted by them is required in the modern public health nurse. In cooperation with the School of Philanthropy (Columbia University) and with the Henry Street Settlement, a year's work has been arranged taking up the following subjects: social economy, medical sociology, psychology, municipal sanitation, industrial hygiene, housing, food economies. A new course this coming year will open up the study of statistics and their bearing upon health and legislation."

* * *

"Through the interest of H.R.H. the Duchess of Connaught, a fund amounting to $221,000 has been raised for the general expansion of the work of the Victorian Order of Nurses. Her Royal Highness is especially anxious to have the work in the sparsely settled parts of Canada developed."

Trends in Nursing

Centralized Lecture Program in Saskatchewan

EARLY IN 1953 students enrolling in the schools of nursing of eight hospitals in Saskatchewan will spend the first four months together either at the University in Saskatoon or at Regina College. The lecture program will provide instruction in the basic sciences by the university staff. After this preliminary instruction the students will return to the hospitals by whom they were recruited, namely: Moose Jaw General and Providence, Moose Jaw; Holy Family and Victoria, Prince Albert; St. Elizabeth's, Humboldt; Yorkton General, Yorkton; Saskatoon City, Saskatoon, and Regina General, Regina. Upon their return to their home hospitals they will have lectures and practice in the clinical fields.

In order to finance this project, which was sponsored originally by the Saskatchewan Registered Nurses' Association, the W. K. Kellogg Foundation is providing $60,000 which will be supplemented at the end of the second year of operation by $5,000 from the Saskatchewan government, and a further $10,000 at the end of the third year. A governing body, representative of the Saskatchewan Departments of Health and Education, the College of Physicians and Surgeons, the Saskatchewan Hospital Association, the Catholic Hospital Conference, the Registered Nurses' Association, the participating hospitals, and the University of Saskatchewan, has been set up. The coordinator of the program and adviser to schools of nursing will be Miss Hazel Keeler and the executive secretary, Miss Lola Wilson. For the actual operation Miss Lucy Willis, M.A., will head the program at Regina College while Miss Gertrude James, M.A., will be director at the University in Saskatoon. As coordinator, Miss Hazel Keeler will assume the over-all direction of the complete project. To deal with immediate business between board meetings, an executive committee of the board has been appointed.

As this is an experiment in basic nursing education, a curriculum committee with wide representation will establish educational standards. This and the representation on the board of the Departments of Health and Education should assist considerably in the development and use of modern educational methods and facilities in nursing.

In addition to the directors mentioned above, each centre will have two registered nurse instructors whose responsibility will be to integrate the courses given by university lecturers and to guide the individual students. A health counsellor and a secretary will complete the staff in both schools. Later, as the students go back to their home schools, a travelling instructor will be appointed to guide and advise, and to coordinate the previous teaching.

It will be very interesting to see the results of this program. Over a long period of time the need has been felt for a centralization of the teaching of basic sciences. With the use of the well equipped laboratories of the university and the influence of the specially prepared university staff, much improvement in the understanding of basic principles in nursing and in medical treatment should soon be evident. Instructors in the smaller schools of nursing will feel that a great weight has been lifted from their shoulders. One has only to review statistics on the number of courses needing to be taught and the number of instructors available to realize how heavy has been the burden. As well as this, the effect of the cooperative venture should leave its mark in an increasing spirit of mutual understanding among the students in all the schools.

Items from the I.C.N. Newsletter

Both the president and the executive secretary of the I.C.N have been making field trips. Miss Gerda Höjer, the president, in the course of a Mediterranean tour has been contacting nurses

in every port where time allowed. We will look forward with interest to an account of this journey which has included Greece, Turkey, and Israel. Miss Daisy Bridges returned from her visit to India, Ceylon and Pakistan, where she was met with the warmest of welcomes from the nurses of those countries. While she was in India she attended the annual conference of the Trained Nurses Association in Delhi.

The Florence Nightingale International Foundation (Education Division of the I.C.N.) announces that Miss Jean Campbell has replaced Miss Frances Beck on the F.N.I.F. staff. Miss Beck is at present attending Teachers College, Columbia University.

In regard to the study of Advanced Programs in Nursing Education, out of 47 countries contacted, 27 have stated that they have advanced programs of various kinds in nursing education.

While mentioning the I.C.N. we cannot neglect the congress in Brazil from July 12 to 17, 1953. We have received a copy of the tentative program which, although not yet in detail, promises much of interest to all branches of nursing. If you are interested in going, a note to the C.N.A. National Office will bring you additional information.

Trends in Industrial Nursing

So often our interpretation of the term "industrial nurse" brings to mind a nurse who bandages, inoculates, examines and polices the employees of an industrial concern. We think of her as making "home visits" partly to advise in the care of the employee but predominately to see whether he is really ill or just taking some extra time off. Investigation reveals that industrial nursing is much wider in scope. The nurse must be expert in surgical nursing, health teaching and counselling and be active in the safety program. She must know and like records so that she can keep them efficiently and, through them, interpret her services to both management and labor. Through an understanding of the world of business and the men who run it, she can assist in building friendly relationships within industry. Most of all she must be emotionally mature so that she can work objectively with both men and women, with management and labor. She is often a public relations officer for nursing in the business world.

We must think, too, of what factors are to be considered by the nurse who wishes to do industrial nursing. Industry is being decentralized. More and more large plants are being built away from the larger cities to allow for greater expansion. When a new site is chosen, factors considered are: transportation for raw materials and the finished products; the community friendliness towards the industry and the employees it may import; the source of manpower available; the accessibility of raw materials, etc. All this means that the nurse in the industrial health services of the future must be willing to move out from the large cities or plan a means of transportation to the new industrial centre. Age, as in many other fields of nursing, is a factor that must be considered. Industry considers age because of their benefit plans. However, although many concerns will not consider a nurse over 40, others prefer the older nurse. It is usually less of a problem if she is already known in the community. Whatever the situation, the nurse must be ready to accept this factor in employment.

In view of all this, industrial nursing provides opportunities for nurses who are eager to give a much needed service and who are willing to help develop an expanding field.

Budgeting for Banff

If ever a person was busier than a lone nurse on a ward with six doctors wanting attention, then it is Mrs. Clerk, our convention manager. She has searched out some financial facts that will help us all get to Banff in '54. Did you know that those members who live farthest from Banff can get to the convention by starting to hoard *four dollars a week* right now? According to information available, this will allow you to travel in comfort and to spend five days at the Banff Springs Hotel.

New Films

Four films are now being screened by the National Film Board which will be of interest to obstetrical nurses and

public health nurses carrying out pre- and postnatal care programs:

1. *Prenatal care:* This outlines the principles of prenatal care so that a young mother can understand the essential quality of normality.
2. *Labor and childbirth:* This is designed to give expectant mothers a preview of their hospital confinement and an explanation of the mechanism of labor.
3. *A normal birth:* This is a literal photographic record of a normal delivery with the mother conscious and able to cooperate.
4. *Postnatal care:* This deals with the proper care of the mother in the first weeks after childbirth. It includes advice on postnatal hygiene for the mother, breast feeding, exercises and other important points.

From the point of view of technic these films appear to be above reproach. The material is presented simply. The whole aim is to give the mother a better understanding of the process of childbirth without shocking her with extraneous detail. On the whole, they are very well done. Further information should be available from the National Film Board office in your vicinity.

Orientation et Tendances en Nursing

Centralisation des Cours en Saskatchewan

Au debut de 1953 les étudiantes des écoles d'infirmières de huit hôpitaux passeront les quatre premiers mois de leurs cours ensemble, soit à l'Université de Saskatchewan à Saskatoon, soit au Collège de Régina. Le personnel de l'Université leur enseignera les sciences de base. Une fois le cours préliminaire terminé, les étudiantes retourneront à l'école où elles s'étaient inscrites, à savoir: Moose Jaw Général et Providence, Moose Jaw; Holy Family et Victoria, Prince Albert; St. Elizabeth's, Humboldt; Yorkton General, Yorkton; Saskatoon City, Saskatoon; et Régina Général, Régina. Une fois revenues à leur hôpital respectif, les étudiantes recevront d'autres cours et une expérience clinique.

Cette entreprise fut d'abord un projet de l'Association des Infirmières Enregistrées de la Saskatchewan. Elle est financée par la W.K. Kellogg Foundation qui donne un montant de $60,000. A la deuxième année de l'expérience, le Gouvernement de la Saskatchewan donnera $5,000 et $10,000 à la fin de la troisième année. Un bureau de directeurs a été formé de représentants des Ministères de la Santé et de l'Education de la Saskatchewan, du Collège des Médecins et Chirurgiens, de l'Association des Hôpitaux de la Saskatchewan, de la Conférence des Hôpitaux Catholiques, de l'Association des Infirmières Enregistrées, de l'Université de Saskatchewan, et des hôpitaux participants. La coordinatrice du programme et l'aviseur des écoles d'infirmières sera Mlle Hazel Keeler et la secrétaire exécutive, Mlle Lola Wilson. Le travail sera dirigé au Regina College par Mlle Lucy Willis, M.A., et à l'Université par Mlle G. James, M.A. Comme cette entreprise est une expérience dans l'enseignement du nursing, un comité du programme, composé de nombreux représentants, établira les normes de l'instruction.

Nous espérons, grâce à ces diverses représentations, particulièrement celle du Ministère de l'Instruction et de Santé, un développement considérable dans les méthodes d'enseignement et de travail en nursing. En plus des personnes déjà mentionnées, chaque centre aura deux infirmières institutrices, chargées de compléter les cours donnés à l'Université et de guider chaque étudiante. Une conseillère en santé et une secrétaire compléteraient le personnel de chacune des écoles. Plus tard, lorsque les étudiantes retourneront à leur école respective, une institutrice voyagera d'école en école, afin de guider et conseiller dans la coordination de l'enseignement déjà donné.

Il sera intéressant de surveiller les résultats de ce programme. Depuis longtemps l'on sentait le besoin de centraliser l'enseignement des sciences de base. Les laboratoires bien outillés et l'enseignement de professeurs bien préparés de l'université aideront à faire mieux comprendre les principes du nursing et des soins aux malades. Les institutrices dans les petites écoles d'infirmières vont sentir qu'elles ont été soulagées d'un lourd fardeau.

La coopération montrée dans cette entreprise

intéressante laissera nous n'en doutons pas la marque d'une meilleure entente entre les étudiantes de toutes les écoles.

Extraits de la Lettre du C.I.I.

La présidente et la secrétaire du Conseil International des Infirmières font une enquête sur place. Mlle Gerda Höjer, la présidente, au cours d'un voyage de repos en Méditerranée, s'est fait un devoir de rencontrer les infirmières à chaque escale assez longue. Nous anticipons l'intérêt que nous donnera la lecture du rapport de ce voyage en Grèce, en Turquie et en Israël, etc. Mlle D. Bridges revient d'un voyage aux Indes, au Ceylan et au Pakistan où elle a été reçue avec une chaleureuse bienvenue. A Delhi, elle a assisté à la conférence annuelle de la "Trained Nurses Association."

Mlle Jean Campbell a été nommée membre du personnel de la Florence Nightingale International Foundation (Education Division of the I.C.N.).

En parlant du C.I.I., nous ne pouvons oublier de mentionner le Congrès du Brésil du 12 au 17 juillet 1953. Un programme a été élaboré. Bien que nous n'ayons pas encore tous les détails, il paraît très intéressant pour tous les groupes d'infirmières. Les infirmières désirant plus de renseignements sont priées de s'adresser au Secrétariat National de l'A.I.C.

Le Nursing en Industrie

Souvent nous nous représentons une infirmière en industrie occupée à poser des bandes, à vacciner et à surveiller les absences des employés et ce, pour le compte d'une industrie. Nous la voyons faire des visites à domicile en partie dans le but de renseigner sur les meilleurs soins à donner à l'employé mais surtout dans le but de contrôler s'il est réellement malade ou s'il prend un congé additionnel. Une étude attentive du travail de l'infirmière en industrie révèle que son champ d'action est beaucoup plus grand. L'infirmière doit être une experte en nursing, en chirurgie, dans l'enseignement de la santé, et prendre une part active dans le programme de sécurité. Elle doit connaître et aimer la préparation des fiches, elle doit les tenir à jour et avoir les renseignements qui lui permettraient d'interpréter son travail aux employés comme à l'employeur. Si elle comprend bien le monde des affaires et les hommes qui les dirigent, elle peut aider à établir de bonnes relations dans l'industrie. Avant tout elle doit avoir une maturité émotionnelle, lui permettant de travailler objectivement aussi bien avec les hommes qu'avec les femmes, avec le directeur de l'usine qu'avec les employés. Souvent dans le monde des affaires, l'infirmière en industrie est le meilleur agent des relations extérieures de la profession.

Les infirmières, désirant travailler dans une industrie, doivent considérer que de plus en plus les industries s'établissent en dehors des grands centres, ce qui permet de réaliser des agrandissements. En choisissant un site plusieurs facteurs sont considérés—le transport de la matière première et le marché du produit manufacturé; la bienveillance de la population envers l'industrie et les employés qu'elle amènera; la main-d'œuvre disponible. Tout cela veut dire que dans l'avenir l'infirmière dans l'industrie doit être prête à abondonner les grandes villes ou voyager au nouveau centre industriel.

Un autre facteur dont il faut tenir compte en industrie est l'âge à cause des caisses de retraite. Dans certaines industries une infirmière âgée de plus de 40 ne sera pas acceptée; dans d'autres l'on préfère une infirmière plus âgée. Si l'infirmière connaît le milieu où elle est appelée à travailler, elle a une meilleure chance d'emploi mais il ne faut pas oublier que le facteur âge est important en industrie.

Preparer Votre Budget pour la Convention de Banff

Si vous désirez aller à Banff en 1954 même si vous demeurez à l'extrémité du pays la chose est possible si régulièrement vous mettez de côté $4.00 par semaine. Brisez votre tirelire ou fermez votre compte de banque et avec la somme économisée vous pourrez vous rendre à Banff et passer cinq jours au magnifique Banff Springs Hotel.

Films Nouveaux

Quatre films ont été préparés par l'Office National du Film. Ils intéresseront tout particulièrement les infirmières en obstétrique et en hygiène publique chargées de l'enseignement pré- et post-natal:

1. *Soins avant la naissance*—Ce film indique les principes que doit connaître la jeune mère afin d'assurer une naissance normale de son enfant.

2. *Travail et accouchement*—Le film a pour but de donner à la future mère une idée de l'accouchement à l'hôpital et d'expliquer le mécanisme du travail.

3. *Une naissance normale*—C'est une repro-

duction exacte d'un accouchement. La mère est consciente et coopère.

4. *Soins après la naissance*—Les soins à donner à la mère durant la première semaine après la naissance; des conseils sur l'hygiène après la naissance, l'allaitement maternel, les exercices, etc.

Au point de vue technique, ces films semblent parfaits. Le but est de renseigner la mère sur l'accouchement sans l'effrayer par toutes sortes de détails. Pour plus de renseignements adressez vous à l'Office National du Film de votre ville.

Pour aider nos infirmières se dévouant aux soins des nourrissons, la première partie d'un intéressant article sur les soins à donner aux prématurés se trouve dans ce numéro. Avec Mlle Z. Oppliger, monitrice de la Maternité Universitaire de l'Hôpital St-Pierre, Bruxelles, nous disons:

"Le service des prématurés a un tel degré de spécialisation qu'il exige un personnel spécialement choisi. Il est inutile d'y mettre des infirmières n'aimant pas les enfants ni ce genre de travail. Quelle tâche passionnante de sauver des petits êtres absolument sans défense ni ressources."

Chronic Use of Drugs

THE AMOUNT OF DRUG addiction in any given country depends on the number of neurotics among the population and on how many of these neurotics have experienced the sensation of euphoria produced by a drug, "whether in consequence of therapeutic treatment with opiates or through yielding to enticement."

This is the conclusion of Dr. Erich Knaffl-Lenz, professor at the University of Vienna and an expert in pharmacological and chemical questions, writing on the causes of the chronic abuse of narcotic drugs in the latest *Bulletin on Narcotics,* published by the United Nations Department of Social Affairs.

The main cause of drug addiction, says Dr. Knaffl-Lenz, seems to be a phenomenon of civilization caused "by the enervating life of large towns and insufficient regeneration through the admixture of healthy peasant blood." The incidence of addiction, in his opinion, is, therefore, incomparably greater in towns than in the country.

Prohibition and strict supervision of narcotic drugs does not supply the whole solution, the writer states. If only these counter-measures were employed, the result would merely be the substitution of still more dangerous drugs, as was the case in China, for example, where smoking opium was replaced by morphine and heroin imported by the ton from abroad.

It can, therefore, be assumed, states Dr. Knaffl-Lenz, that the misuse of narcotic drugs is confined almost exclusively to people whose nervous system has sustained injury, and that normal people have at their disposal a sufficiently harmless means of making life more worth living by material, spiritual or esthetic pleasures. On the other hand, in the case of oriental peoples, the addicts are for the most part normal people, "who seek in the intoxicating effects of narcotics a temporary liberation from the troubles of their everyday life."

Dr. Knaffl-Lenz outlines in an eight-page lead article of the *Bulletin* other causes of the use and misuse of drugs which affect the central nervous systems of individuals. Some of them, such as spices, caffeine-containing beverages and tobacco, he regards as harmless and merely a means of enjoyment; while others, such as alcohol, opium, morphine, heroin, become dangerous poisons if taken in excess.

Of the former category — the harmless drugs — he states that they possess not merely sensory but mental properties. Smell, color and taste affect the senses pleasantly, thereby furnishing esthetic pleasures, creating illusions, inducing pleasant moods, suppressing the consciousness of inhibiting influences, and thus providing temporary

(Continued on page 135)

Student Nurses

To Know, To Do

A. VIBERT DOUGLAS

I AM GRATEFUL for this opportunity to congratulate the graduating nurses on the completion of their years of training for the diplomas which they have won.

I congratulate their instructors and supervisors. I have not been an educator for 30 years without knowing well the satisfaction of seeing a class arrive at their graduation after the long hard climb upwards towards the goal of their aspirations.

Some time ago I was in London and, walking down from Piccadilly Circus towards St. James's Park, I looked at the bronze statues of Florence Nightingale and of Sidney Herbert, whom she made her spokesman in Parliament. I thought of this graduation ceremony to which I was invited and the contrast between the status of nursing 100 years ago and today. How much the world owes to courageous pioneers who, not content with the *status quo* but seeing a great need or an opportunity for constructive improvement, go forward undaunted by apathy and opposition. By effort and thought and faith they achieve the almost impossible. No wonder the British government in 1907, when Florence Nightingale was 87 years of age, advised the King to confer upon her the high and most exclusive distinction — the Order of Merit.

There is a little-known poem by Lord Warren, Baron de Tabley, which I am going to quote because it portrays two attitudes to life — that of the complacent drifter and that of men and women of the calibre of those who have been leaders in the medical and nursing professions:

To know, to do, and on the tide of time
Not to drift idly like a cockle sailor
Whose pearly shallop dances on the blue,
Fanned by soft airs, and basking in brief sun,
Then as a cloudlet sinks, with scarce a ripple;
But to steer onward to some purposed haven
And make new waves with motion of our own,
That is to live.

There is the challenge to the young graduate. *To know, to do — to make new waves with motion of our own.* Neither knowledge alone, nor action alone is enough. The French philosopher, Bergson, put it thus: "Think like a man of action; act like a man of thought."

A good teacher is not one who helps students successfully to memorize a static list of facts but one who gives students the vision of knowledge as a great river flowing through the centuries, gaining volume and momentum by the trickles and streams and tributaries of new knowledge being added to it continually. This dynamic picture of knowledge implies that we must continue to learn and to study if we are to keep abreast of knowledge. It is hard work but it is essential if you are to maintain your professional standing. You will come to take a pride in so doing.

I hope some of you will go on sooner or later to post-graduate courses. I hope you will become research workers while you practise your profession with minds and imaginations open to new ideas, possibly new methods and approaches to old problems. Some of you may become teachers and, if you do, put all the enthusiasm of which

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Dr. Douglas is dean of women at Queen's University, Kingston, Ontario. This address was delivered at the graduation exercises of the Women's College Hospital, Toronto.

you are capable into your teaching and keep the dynamic picture of knowledge before you.

Your profession is often described as both an art and a science. As a science it demands conscientious accuracy and sound basic knowledge of the fundamental subjects of chemistry, physics, biology, anatomy, bacteriology; it demands skills and techniques undreamed of before the discovery of radiology and the many new substances used in chemotherapy; it calls for comprehension of the scientific method, observation, induction, deduction, experimentation, fertile imagination and critical assessment of results.

As an art, nursing calls for great human qualities of heart and hand, of mind and spirit. No one can possess and develop these great human qualities whose outlook is narrowed to the purely professional aspects of the day's work. You will be dealing with people who have been strong and active, who have carried responsibilities, have read and thought perhaps widely and deeply, who may have renewed their spirits with music and the arts, who have been citizens, perhaps with vision beyond the municipality to the nation and out into the international field.

Can you do a first-class job for the sick people entrusted to your care unless you are yourself an educated woman in the best sense of that word? You should make time to read widely, to see what is beautiful and interesting in art and drama, to hear some good music, to keep aware of current events. "Reading makes a full man", wrote Bacon and your aim should be to make for yourself a rich, full life, so full that your zest and ideas overflow, bringing fresh ideas and stimulating thoughts to your patients from time to time and according to what you discover to be their interests. Anyone with "a sizzling enthusiasm for life," to borrow Osbert Sitwell's phrase, will be like a breath of fresh air, like a stimulating ray of ultraviolet light, bringing new hope and encouragement to the sick in body and mind and spirit. No one can overestimate the influence of a nurse of character who has gentleness and dignity, kindliness without sentimentality, efficiency with deep sympathetic understanding — over and above all, a woman of character.

You who are pledged to the tasks of restoring and of maintaining health are part of a vast international army whose campaigns are wholly constructive. When the World Health Organization came into being with 61 nations signing its Constitution on July 22, 1946, a challenging definition of health was put as an ideal before the world — health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

We should all make the effort to know more about and talk more about the great work being done by these agencies of the United Nations — WHO, FAO, IRO, UNICEF, and Unesco. How many people realize the tremendous task which faced IRO in 1947 and the unparalleled achievement which was reported to the General Assembly of the U.N., meeting in Paris? I have seen some of those D.P. camps in Germany and know something of the difficulty of restoring and maintaining health in these crowded camps of war victims — men, women, children — many of them weak with undernourishment, exposure and hardship, after forced labor camps or resistance work, overwrought with tragedy and loss of relatives, of home and homeland — people for whom the future was one large question mark. In its four and a half years IRO transported to new homes all over the globe more than 1,000,000 people, many in its own ships — at its height said to be one of the greatest fleets in all history. It repatriated 73,000 but over a million others for political reasons could not return home and were resettled in other countries. Eighteen member governments contributed $400,000,000 for this stupendous task, "probably the most remarkable achievement of any international body in peacetime."

I think we do well to remind ourselves, and those with whom we live and work, of the many things going on around us which are good

and true and constructive. Only by so doing can we avoid being oppressed and discouraged by the evil, selfishness, suspicion and unrest which exist in the world today. We need the stability which comes from facing the facts of existence courageously and honestly. No wishful thinking can produce stability. Let us seek the truth and think our way through to a philosophy of life and behavior that rings true to our experience.

I think our mental and spiritual stability depends upon the sincerity of our belief in the ultimate supremacy of good over evil, of truth over falsehood. But truth is the daughter of time, as Bacon realized three centuries ago. The forces of nature, including human nature, work slowly, with few exceptions. It is imperative that we learn to think in centuries. We must not be discouraged because the millenium is not here now or likely to be achieved in our lifetime. We must have faith that everything that is true and good, tolerant and kind, is not lost but is constructively built into the future of mankind. And it is the sum total of all the little acts of today that partly determine the nature of tomorrow.

My message to you is, therefore, first, that of Zoroaster: "Do thy tasks and live thy life and neither fear nor worship the powers of evil"; and, secondly, that of Renan who pointed out the example of Jesus of Nazareth with these words: "He infused into the world a new spirit . . . the perfect nobility of the children of God."

Agnes and Louise

LESTRA SCOTT MACLEAN

Each student nurse has her individual background of experiences which combine to make her the kind of person she is and have led her to choose this profession. Everything that she has ever done has been building up to the point when she enters nursing.

One hazy September day, Mrs. Jones arrived at the school of nursing with her two nieces—Louise and Agnes. Louise was an only child and accustomed to much attention, whereas Agnes had been brought up with six other children and was used to helping the others. When they were little girls, they had played hospital together. Agnes always wanted to be the nurse while Louise wanted to be the wealthy patient. Agnes knew then what she wanted to be but Louise changed her mind every week. The girls were accepted into the school and started their three-year training period.

Miss MacLean is a student nurse at the General Hospital, Glace Bay, N.S.

Agnes was a rather shy, quiet, withdrawn girl. Louise was always the centre of attraction and she didn't expect to be anything else. It is well known that nurses take with them their habits in relation to their families, their social habits and attitudes, their emotional habits, their subject matter preference and prejudices, their special academic background and many imperfect study habits. Agnes was fairly well prepared to start work although she had to learn to develop confidence, which is important in working with and meeting people. Louise, on the other hand, had no intention of settling down because when she was in high school she never had to do any work—someone always did her assignments for her! She and a few other girls were much more interested in the local boys and the weekly dances.

Both girls were confronted by learning situations which were different from those to which they had been accustomed in high school. Agnes found it was

hard enough to do her own studying without worrying about her cousin. She must often memorize content, learn new motor skills, organize her knowledge for early use. Louise didn't have time to worry about such things but Agnes was trying her hardest to keep up with the class. Louise had not been accustomed to making her bed or cleaning her room. Why, her mother always did that! Now Louise didn't think she should have to do it. Agnes was used to looking after herself and she did not have to make any adjustment here.

The big day came and they started their work on the wards. Agnes was scared and rather shy but Louise—oh well! she was used to talking to people. They both were assigned to elderly ladies for patients. Louise talked about dances and parties, which her patient found rather boring. Louise was not thinking too much about the patient—she was still her own idol and liked to tell everyone about it. On the other hand Agnes started talking about knitting and children so her patient forgot about her illness and carried on most of the conversation. The woman could easily tell that Agnes was interested in her and this give her a special lift.

There was a vast difference in the girls in this respect. Agnes was greatly interested in the patients and tried to help them. She was always doing little extra things for them. Louise had trouble just doing the required work; she never bothered to do extra things for her patients because she had a motto, "God helps those who help themselves."

Agnes was doing her job well. The recognition of her goal was an aid to learning and to efficiency in practice. Louise was just doing enough to get by. One evening the other students wanted to go to a show but Louise wanted to go to a dance. Since she couldn't have her own way she stayed home. To her surprise she discovered that the other students got along very happily without her. Somewhat chagrined, she began to realize she wasn't the pivot she thought she was. Little by little she began to change and see things in a different light As she saw herself in this new perspective she gained a new insight into nursing. She treated the patients as real human beings. "After all," she thought, "they have feelings. If my feelings can be hurt, their feelings can also be hurt."

Some of the nurses had developed feelings of hostility toward Louise because she thought so much of herself and didn't think she should do so much work. After all it meant that somebody else would have to do her jobs. Gradually as her changed point of view broadened, Louise found that it was really interesting to do all of her own work and be responsible for certain duties.

Everyone sometimes makes mistakes. Mistakes are only natural but some people seem to make more than others —they just don't seem to think! Agnes was no exception. She made mistakes and she confessed them. At first, Louise made mistakes and just ignored them. Someone else could take the blame! But when she saw that other girls were able to stand up and take the blame, it was then that she decided she was old enough to be responsible for what she was doing and she owned up to her mistakes.

With the acquisition of new knowledge and skills a person may anticipate changes in personality. We have seen that this is true. Before a girl enters a nursing school she must have a genuine desire to help others. Some girls just out of high school do not realize that when they come in training they are going to work hard and help others. They come for the glory of the uniform and profession and that is why they become displeased. They don't know why they came nor what to look for.

In this profession the motto which Louise had—"God helps those who help themselves"—certainly does not hold. We might suggest slight modifications in it that change the meaning entirely. Like Louise we might say, "We help God to help those who can or cannot help themselves, for nursing is our profession."

A single nurse-midwife gave three-month courses for untrained midwives in certain provinces of Mexico.

As a result, infant mortality rates in one community dropped, in two years, from 223 per 1,000 to 112.

Chronic Use of Drugs

(Continued from page 130)

distraction from the cares of everyday life. Their mental action, he believes, can stimulate or facilitate intellectual or creative work. But the extent of such action is substantially affected not only by the personality structure but also by the cultural level of the user. "It may, therefore, well be that intellectual workers — scholars, musicians, artists, and writers — are precisely those who have a stronger and more varied need for such drugs."

Taking as an example the use of tobacco, Dr. Knaffl-Lenz states that the nicotine content does not play a decisive role in the enjoyment of tobacco. Decisive factors, in his opinion, are the packing, the form and color of the cigar, the wrapper, the aroma and the type of pipe. "All the senses are engaged in smoking — touch, sight, smell, and taste. Feelings of hostility which might be aroused by an unwelcome interruption of work do not materialize because the occupation of all the senses produces an impression of activity which is, in fact, nonexistent. Boredom does not arise, mental work is more readily accomplished, disturbing anxiety is relieved, fatigue is banished, and preoccupation with the ego is lessened with a resultant increase in sociability." These psychical effects, he declares, "facilitate the course of negotiations, as we know from the pipe of peace and the good cigar."

With neurotics, however, tobaccos with a low nicotine content do not produce the desired effect. Addiction soon develops, as does a craving for the effect of nicotine, which is difficult to suppress. The pure "means of enjoyment" thus becomes an intoxicant.

He describes a similar situation in the case of alcohol. When consumed in moderation it can be regarded as a harmless means of enjoyment. However, when consumed in the form of more or less diluted pure alcohol for the purpose of producing intoxication, there is the risk of chronic abuse and of serious damage to health.

The value of caffeine-containing beverages as stimulants is due almost exclusively to the stimulating effect of caffeine on the brain, as a result of which fatigue is banished, mental concentration and the process of thought facilitated, and a mild state of euphoria produced. Physical capacities are also heightened. "The psychomotor stimulation, which is not unwelcome in sport but is disturbing to mental activity, is weakened by the volatile oils contained in tea. Tea is, therefore, the appropriate stimulant for intellectual workers and coffee for those who engage in sport," he declares.

Turning to the more dangerous drugs taken for their effect on the brain, such as opium, morphine, cocaine, etc., Dr. Knaffl-Lenz says that people predisposed to addiction to these drugs belong to a type of neurotic "characterized by a disparity between their abilities and their need for recognition." He attributes this disparity not to lack of intelligence but to "reduced powers of concentration and endurance, caused in turn partly by overexcitability and partly by the tendency of the nervous system to become easily and quickly fatigued." Their reaction to opiates is with a hitherto unknown feeling of well-being and happiness — euphoria. The desire for a repetition of this experience soon asserts itself and demands ever-increasing doses. In the end, the individual is unable any longer to withstand this morbid desire unaided. If the desire is not satisfied by a renewed dose of morphine, severe morbid mental and physical symptoms appear and create a compulsion to further misuse of the drug.

Dr. Knaffl-Lenz regards this type of addiction as a latent disease which does not manifest itself until morphine is administered for the first time. And, he adds, often the symptoms of a disposition to addiction can be traced back to early infancy and include lack of appetite, hypersensitivity to noises, smells and pains, susceptibility to mental and physical fatigue, disturbed sleep, inclination to depression and vasomotor disturbances, etc.

The *Bulletin on Narcotics*, Vol. IV, No. 4, October-December 1952, may be obtained through United Nations sales agents throughout the world and in Canada from *The Ryerson Press, 299 Queen St. W., Toronto 2B, Ontario.* (Price 50 cents per copy.)

Book Reviews

Working Programs in Mental Hospitals

Proceedings of the Third Mental Hospital Institute held under the auspices of the Mental Hospital Service of the American Psychiatric Association. Edited by Daniel Blain, M.D., Medical Director, A.P.A., with the staff of the A.P.A. Mental Hospital Service. 203 pages. American Psychiatric Association, 1785 Massachusetts Ave. N.W., Washington 6, D.C. 1952. Price $2.50 (in U.S.A.).

Reviewed by Ella G. Smith, Supt. of Nurses, Ontario Hospital, Kingston.

This book differs from most textbooks as it is an actual record of the discussions at a Mental Hospital Institute held in Louisville, Kentucky. In the majority of topics there was a brief introduction followed by free discussion from the floor. The group included psychiatrists, nurses, hospital administrators, business managers, board representatives, social workers, and psychiatric aides. These people were all meeting with one common interest—how to contribute most in providing better care for the mentally ill patient.

It was also implied that greater effort should be made in getting psychiatry accepted by the general medical profession as a medical entity. It is encouraging to note the hospital-university relationship in many centres. Members of the hospital staff are given definite positions in the medical school: university consultants in turn visit the mental hospital, giving their services to the patient. A closer relationship is also developing with general hospitals. In some parts of Canada the graduate receives six months' training in a general hospital, six months in a mental hospital, and the remainder of his training in the university.

Stress was placed on the attempt to have the mental hospital accepted as part of the community. It is necessary that all workers keep a constant persistent pressure toward adequate social integration—basic to trying to get the patient back into the community before he wants to remain in this protective environment. A challenge was given to the social agencies to provide that their workers visit and give aid to these patients on their return to the community.

In order to accomplish this aim one medical superintendent called in the county medical societies. On the program a neurosurgeon presented four cases, after which a group therapy class was held, then the translobar lobotomy patients were called in. Group therapy is being used extensively as well as individual psychotherapy. It is felt electroshock will find its place. In the discussion of intensive treatment, the value of teamwork with all workers was pointed out, communication being the keyword.

To fill the need for better trained staff, in-service programs are arranged in the majority of hospitals. Curricula are compiled and forwarded to the Nursing League for approval. Registered nurses are being encouraged to come on the staff and many hospitals, providing affiliation for student nurses, find this personnel returning to the wards as graduates to learn more about psychiatric nursing.

This book is not suitable as a student reference but is highly recommended to workers interested in the field of psychiatry. Instructors organizing courses will find it stimulating.

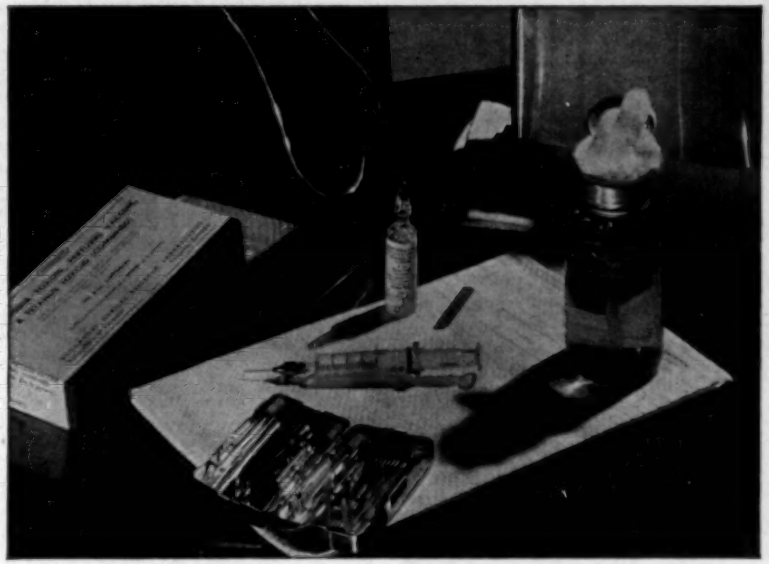
Cerebral Palsy Institute Proceedings—

November, 1950. Sponsored by the Coordinating Council for Cerebral Palsy in New York City, Inc. Prepared by Marguerite Abbott, B.S., O.T.R. Association for the Aid of Crippled Children, Inc., 580 Fifth Ave., New York City 19. 1952. Price $1.50.

Reviewed by Zelma Creeden, Assistant to the Director of Nursing Service, Ontario Society for Crippled Children, in consultation with Mrs. Claribel Richards, Cerebral Palsy Coordinator, Cerebral Palsy Division, Ontario Society for Crippled Children.

This manual contains 31 papers compiled from contributions made by Doctors Phelps, Perlstein, Palmer, Deaver and many other well known professional personnel experienced in their own particular field.

These articles take one chronologically through the many possible treatments and phases of rehabilitation of the cerebral palsied child, including: etiology and diagnosis; role of drugs and orthopedic surgery in treatment; the pediatric and clinical aspects; types of therapeutic treatments; in- and out-patient facilities; training and care in the home and treatment centre; organization for cerebral palsy services; the role of the nurse, social worker, rehabilitation officer; special education, vocational guidance, training, and employment; also the parents' viewpoint.



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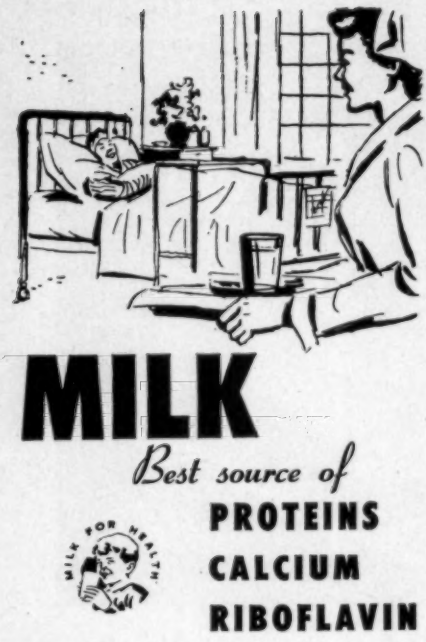


These selected articles should be of inestimable value to all those engaged professionally in the cerebral palsy field since they: (1) give the reader a wider vision of the many phases and aims of treatment, rehabilitation, and adjustment; (2) illustrate that the maximum benefit to the patient can only be realized with the cooperation of the patient and assistance by the parents.

At present there is a shortage of literature dealing with the over-all picture of cerebral palsy which further emphasizes the value of this publication.

Aids to Gynaecological Nursing, by Hilda M. Gration, S.R.N. and Dorothy L. Holland, S.R.N. 205 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 5th Ed. 1952. Price $1.00.

Reviewed by Rozalia A. Manchuk, Red Cross Outpost Hospital, Hudson Hope, B.C.

This revised edition is very well written, concise and to the point. It provides a quick reference for the graduate nurse and an introduction for the student nurse to all gynecological topics which include: the anatomy of the female generative organs; physiology of the ovaries, implantation of the ovum and development of the fetus; disorders of menstruation, antenatal care and complications of pregnancy; nursing during puerperium; displacement of the uterus and operations for prolapse; venereal diseases; infertility; new growths of the uterus and ovaries. It also includes nursing care of the gynecological cases and post-operative complications and treatments. The effect of endocrine secretions on the genital tract is an important factor mentioned, showing that the pituitary gland and the ovaries are directly concerned with the functioning of the genital organs, with the therapeutic use of hormones where dysfunction takes place.

This text is very good as a reference for the graduate nurse and student but it would not suffice for complete study of gynecology for the student nurse.

The Menopause, by Lena Levine, M.D. and Beka Doherty. 198 pages. Random House of Canada Ltd., 1149 King St. W., Toronto 3. 1952. Price $3.50.

Reviewed by Mrs. N. T. Bennett of Chemainus, B.C.

The book deals with this phase of gynecology in a direct, easily read and concise manner. It is divided into five sections, namely: (1) What is the menopause? (2) What is a woman? (3) What really happens? (4) What can be done? (5) What of the future?

The first section deals with the age-old fears and superstitions which have impeded the study and relief of the menopausal discomforts. It shows clearly that the menopause is just what the word means — the cessation of menstruation.

The second section deals with various theories throughout former and modern times as to the physical and psychological structure and purpose of women in our society, stressing their limitations and advantages, because they are just that—women.

The third section carries on with the endocrine and physical function of the reproductive system and the changes that take place due to the cessation of activity in the ovaries. It is clearly brought out that a great many illnesses and discomforts of middle age have, for various reasons, been blamed on and labelled menopausal symptoms as though it were a specific disease, despite the fact that many identical complaints are evident in men of the same age and are explained in an entirely different light.

The fourth section states the type of treatment that today may be applied for the actual discomforts of menopause. It stresses the need for thorough medical check-ups at this time to

prevent ailments of this age group, both physical and mental.

The fifth section gives the reader a picture of the part, due to changing opinions and clarification of the menopause, that women will be able to play in the family and outside the home. Also it gives the release from fear the single women may enjoy in their pursuits of careers and their place in society. It states that no longer need women feel limited in mental and physical activities due to the bonds of their physical structure but may feel "proud of being women —all their lives long."

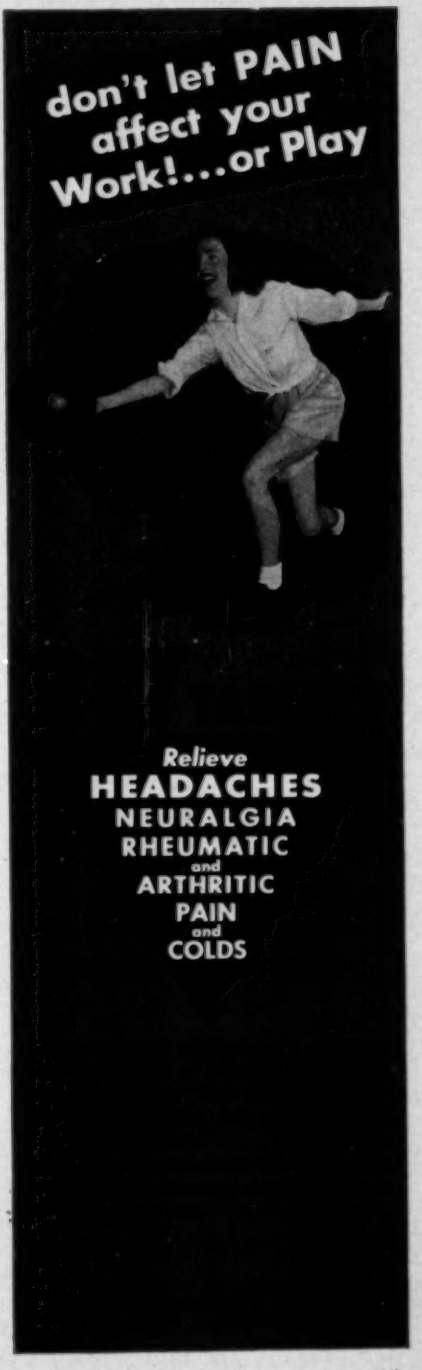
This book will make a valuable addition to the library of any gynecological department and should be a "must" in training of public health personnel, who deal with the well-being of our family life. Because of the technically simplified phrasing the book would make very informative and interesting reading for most women and many husbands. The authors of this book are attempting to awaken people to the principle that the menopause is not a disease but a phase in our lives which should cause in a woman of sound mental and physical health, no greater discomfort than any other phase through which she passes.

Essentials of Public Health, by William P. Shepard, M.D., with collaborators. 581 pages. J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 2nd Ed. 1952. Price $7.00. *Reviewed by Mrs. Marjorie Campbell, formerly Associate Director, School of Nursing, McMaster University, Hamilton.*

Dr. Shepard has written this book "to provide a brief text on public health for medical students and practising physicians." He has met this objective very well and, indeed, has gone beyond it in that this book is of value to allied professions, particularly to nurses who wish to increase their understanding of the public health field.

The book is written in a very clear, simple and interesting fashion. It covers the major tasks of the workers in both official and voluntary agencies. It outlines the scope of the many present-day problems and presents the progress being made in each field. Emphasis is placed on the relationship between the private physician and the public health workers—a relationship that can be applied easily to the nurse. The discussion does not exhaust all available material but at the end of each chapter there is an excellent list of references for the reader who would wish to pursue the subject further.

In this second edition all the charts and tables



have been brought up to date. Recent developments in the public health field have been added, as well as a completely new chapter on public health nursing.

Though the examples used in this book are confined to the United States, the Canadian picture is similar and hence this book would be a valuable addition to a nursing library.

Study Manual Available

The Public Health Service, of the U.S. Federal Security Agency, announces publication of "The Head Nurse Looks at Her Job," a manual for studying head nurse activities in hospitals. The publication offers a method by which hospitals of all sizes may determine how head nurse time is distributed between management duties and duties which could be performed by less skilled nursing personnel. Head nurses themselves have an opportunity to take part in the study and to analyze their own activities in comparison to functions generally accepted as appropriate to the head nurse job.

Prepared by Ruth I. Gillan, R.N., Helen G. Tibbitts, and Dorothy Sutherland, under the direction of Margaret G. Arnstein, R.N., chief of the Division of Nursing Resources, the manual reflects the Division's concern with finding ways of making more nursing care available to the public through the conservation and more effective use of scarce nursing skills.

Dr. Howard A. Rusk, chairman, Health Resources Advisory Committee, Office of Defence Mobilization, has contributed a foreword in which he says: "The use of this study method in a large number of hospitals across the country, followed by the necessary changes in organization, will be a long step forward toward improving nursing services in the most economical way."

The manual is in looseleaf format and may be purchased at ***40 cents*** per copy from the *Superintendent of Documents, Government Printing Office, Washington 25, D.C.*

Entitled *Motion Pictures on Child Life*, a list of films prepared by the Children's Bureau includes more than 450 films on the social, medical, mental, and developmental aspects of child life. The films are grouped under such headings as adolescence, child care and child development, juvenile delinquency, mental health, nutrition, etc. Copies of this list may be obtained from the *Government Printing Office, Washington 25, D.C.*, for ***40 cents.***

Nursing Sisters' Association

Some 33 nursing sisters who served during two world wars gathered at the Nova Scotian Hotel in November for the annual luncheon meeting of the *Halifax Unit*. During the session a two-minute silence was observed in memory of the late Lillian Fitzgerald, a former night supervisor at Camp Hill Hospital and veteran of World War I, who died recently.

Officers elected for the coming months include: President, Matron Faye Rutledge; vice-president, M. MacIsaac; secretary, D. Salton; treasurer, E. Purdy.

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments—Hamilton: *Phyllis Trusdale* (Toronto Western Hosp.). Montreal: *Martha Cox* (Queen Elizabeth Hosp., Montreal), *Laura J. Milne* (University of Alberta School of Nursing), and *Marie Skov* (Statshospital, Sonderborg, Denmark). Vancouver: *Marjorie Joyce* (St. Paul's Hosp., Vancouver) and *Mrs. Elsie Kershaw* (Vancouver Gen. Hosp.). West Vancouver: *Dorothy Jennings* (St. Paul's Hosp., Vancouver).

Transfer — *Mary MacPherson* from Pictou, N.S., to Montreal.

Resignations—London: *Mrs. Mary J. Walters*. Montreal: *Ruth Seidel*. Regina: *Margaret Gronsdahl*. Vancouver: *Margaret Gibson*, *Mmes Elizabeth Bach* and *Janet Couldwell*. Victoria: *Mrs. Isabel Leighton*.

News Notes

ALBERTA

CALGARY

At an executive meeting of District 3 it was suggested that a sum of money be voted for the purpose of buying and sending Christmas parcels overseas. The possibility of each person contributing ten cents per meeting for these parcels was discussed.

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Courses include: Lectures by the Faculty of the Medical School and Nursing School; principles of teaching ward management, principles of supervision; practice in teaching and management of the specialty selected. Full maintenance and stipend provided.

For information address:

The Directress of Nurses, 343 West 50th Street, New York City 19

The following committee conveners were proposed: Program, M. Hulbert, L. Wright; institutional, Sr. M. Trottier; private duty, Mrs. R. Slater; labor relations, Miss Lewis; refreshments, Mrs. M. Duthie; Council of Social Agencies, F. Ferguson; press and *The Canadian Nurse*, Mrs. E. Bland.

Twenty-three members were present at the November meeting of the district when $25 was voted for overseas Christmas parcels. F. Ferguson spoke regarding the Hospital Association meeting and also concerning an A.A.R.N. Council meeting she had attended, with reference to the 1954 C.N.A. biennial convention. The president, Miss Tennant, in the absence of Mrs. J. Carter, gave a report on the refresher course sponsored by the private duty group.

EDMONTON

Following the October meeting of District 7, Dr. Wershoff spoke on "The Rehabilitation of the Jewish People in Israel." The November meeting was held at the University Hospital nurses' residence. Second- and third-year student nurses joined the members to hear the presentation of "A Demonstration of Home Delivery" by Mrs. B. Eben and students of the advanced practical obstetrics course.

JASPER

A meeting of the Edith Cavell Chapter was held at the home of Mrs. Prowse. Previous to the business session, films were viewed on National Defence. The park wardens were invited to take the first aid course along with the nurses. Discussion ensued concerning the advisability of bringing non-registered or undergraduate nurses into the chapter as honorary members. It was decided to review those names presented as to their eligibility for honorary membership.

PINCHER CREEK

Mrs. C. Van Dusen, A.A.R.N. registrar, visited the chapter, presenting to the members a history of the provincial association and growth of the chapters. She presented several interesting features and projects that could be taken up by the local groups. At the October meeting 11 members responded to "Roll Call," by giving the name of a gland and its function. A program committee, consisting of P. Williamson, R. Bishop, and I. Slater, was formed. Seventeen members were present and each one discussed a nerve and its function. Miss Williamson gave a report of a meeting with Mr. Warke of the St. John Ambulance Association. It was decided that courses would be offered by the Association during the coming months. I. Slater gave a talk on "Mines Around Helena."

VIKING

Mrs. Sorenson was in the chair at a meeting of Viking Chapter held at the home of Mrs. Ash. After a discussion with Dr. Caldwell, Mrs. Brower reported that a delegate should be sent to the Chamber of Commerce meeting. An interesting talk was given by Mr. A. Holland on the newer drugs and plastic appliances which are now on the market. A paper on "Epilepsy" was also given.

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BRITISH COLUMBIA

COMOX

Seventy-two members were present at a meeting of Vancouver Island District when nurses were in attendance from Alberni Valley, Chemainus, Duncan, Ladysmith, Nanaimo, and Victoria, in addition to local members. Mrs. V. Tams, vice-president, was in the chair and welcomed the guests on behalf of Plateau Chapter. M. Dunbar, Alberni, reported on her trip to Quebec for the C.N.A. biennial convention as a delegate for the district. The guest speaker for the evening was Rev. J.J. Van Der Leest, Anglican vicar at Courtenay, who described customs and living conditions prevailing in Holland.

NEW DENVER

Sixteen members were present at a meeting of Slocan Chapter with the president, Mrs. O. Johnson, in the chair. The group voted to place a wreath at the Cenotaph on Remembrance Day. Mrs. M. Higgins, district councillor for West Kootenay, reported on the R.N.A.B.C. annual meeting in Victoria. N. Lee, public health nurse, gave the introductory lecture of a series of six on A.B.C. Warfare. At the close of the session, Mrs. J. Black and R. Dunn served refreshments.

VANCOUVER

St. Paul's Hospital

The alumnae bazaar netted $500, with a special thanks to Mrs. M. De La Salle for all her work and planning and to everyone who helped. Gifts collected at the December alumnae Christmas party were donated to the Welfare Department for distribution among the needy.

C. Bond is industrial nurse at the C.N.R. Station. N. (Comerford) Brodie is at I.D.H. nursing polio victims.

WILLIAMS LAKE

The members of the newly formed Williams Lake Area Chapter meet monthly in the nurses' residence of the War Memorial Hospital. The executive consists of: President, Mrs. M. Johnston; vice-president, A. Weins; secretary, Mrs. M. Routledge; treasurer, Mrs. M. McDougall; program-social convener, Y. Parliament.

MANITOBA

BRANDON

The shortage of nurses in Canada results from an increasing demand for their services and not from any decrease in their numbers, Julia Ryfa reported at a meeting of the Association of Graduate Nurses. Miss Ryfa was one of three local members who attended a joint conference of the Manitoba Hospital Association and the M.A.R.N. in Winnipeg. The other two were Mrs. R. Hotson and J. Harding. L. Arnott, president, was in the chair while A. Bennett was program convener.

FLIN FLON

Mrs. McNicol was elected president of the local Graduate Nurses' Association at the annual meeting when committee reports show-

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ed a successful year. Major projects included the sponsoring of a Cancer Tag Day and the annual Nurses' Dance. A suction apparatus was purchased and presented to the General Hospital.

Other officers for the coming months include: Vice-president, Mrs. G. Neufeld; secretary, Mrs. C. R. Delgatty; treasurer, Mrs. D. B. McGilvray. Committee conveners: J. Smith, Mmes F. Hart, Prendiville, B. East, E. Austin, F. Green, B. West.

WINNIPEG
General Hospital

Choral singing, led by the Juvenile Boys Choir, was enjoyed after the December business meeting of the alumnae association. Gifts were also donated by the members for nurses who were ill and for various families. It was voted to hold the annual meeting on the first Wednesday of November instead of in May. The October auction sale was a successful event.

G. Callin, a graduate of the 1941 class, has returned to the hospital staff as surgical teaching supervisor. She was formerly nursing arts instructor at Sherbrooke Hospital, Que.

NEW BRUNSWICK

CAMPBELLTON

A.J. MacMaster was in the chair at a meeting of Campbellton Chapter held at Hotel Dieu. Sr. Dionne gave her report of the N.B.A.R.N. annual meeting as the chapter delegate. Plans were made by the Ways and Means Committee for a home-cooking sale. Jean Haynes of the V.O.N. gave an informative address and demonstration on the Sister Kenny treatment of polio cases.

EDMUNDSTON

A Christmas party was enjoyed following the annual meeting of the Edmundston Chapter when the members met at the home of C. Pichette. Cards were played, gifts distributed and refreshments were supplied by G. Stevens, Mmes E. Chandler, M. Madore, H. Emmerson, and N. Piddock. Assisting the hostess in serving were: Y. Picard, F. Michaud, J. Nobert, J. Guerette, B. Pettigrew, and Mrs. M. Albert.

Miss Stevens presided at the annual meeting when reports from the standing committees were heard. Revised by-laws were adopted at this time.

The following officers will serve during the coming months: President, C. Pichette; vice-presidents, J. Guerette, Mrs. B. Dumont; secretary, B. Pettigrew; treasurer, Mrs. E. Chandler. The chairmen of the standing committees include: F. Michaud, C. Tobin, Y. Verret, J. St. Germain, Mmes A. Pelletier, N. Piddock, and L. Bernier.

MONCTON
Hotel Dieu

A Christmas party was held, which included alumnae association members and graduate staff, when gifts were exchanged and lunch served. During the November alumnae meet-

ing, Dr. L. J. Gaudet of the medical staff showed a recreational film. Charlotte LeBlanc, past president of the alumnae, is now on the staff of Victoria General Hospital, Halifax.

ST. STEPHEN

The annual meeting of St. Stephen Chapter was preceded by a turkey dinner. The guest speaker was Isabel Lane, adviser to the schools of nursing in the province. She discussed the N.B.A.R.N. annual meeting.

The December meeting of the chapter was held at the home of Joan McMorran at Oak Hill. Following business, the nurses enjoyed a social hour when gifts were distributed to each member from the Christmas tree.

WOODSTOCK

At a meeting of Woodstock Chapter the following conveners were appointed: Public health, Mrs. L. Smith; private duty, P. Jackson; institutional nursing, Mrs. F. Hanson; representative to *The Canadian Nurse*, Mrs. W. Adair. Mrs. Adair gave a report of the N.B.A.R.N. annual meeting held last September in Saint John. Refreshments were served by H. Bull, Mmes P. Raymond and Hanson.

NOVA SCOTIA

At a R.N.A.N.S. executive meeting held in October, Rhoda MacDonald, newly appointed School of Nursing Adviser (see Nursing Profiles, Jan. issue), presented her plan of operation as adviser. Miss MacDonald had made a trial visit to several schools and the committee received her report with a great deal of enthusiasm. The value of her assistance was immediately felt among the directors of the schools of nursing who feel that at long last they have someone to turn to for help and advice.

HALIFAX

The Halifax Branch, R.N.A.N.S., received with regret the resignation of their president, Jean MacLean, who is leaving the city. She has been with the Red Cross for several years as supervisor of outpost hospitals for Nova Scotia.

The Halifax branch of the alumnae of the McGill School for Graduate Nurses met for a fall gathering when Marjorie Jenkins was honored. An active member of the profession for many years, Miss Jenkins has been appointed student counsellor with the Ottawa Civic Hospital School of Nursing.

Victoria General Hospital

A special speaker at a meeting of the alumnae association was A. A. DeBard, city manager for Halifax, who spoke on "Council-Manager Government." Contributions were voted to the local Community Chest and to the Salvation Army campaign.

PICTOU COUNTY

A most successful lecture series on recent developments in the obstetrical, neurosurgical, and psychiatric fields was held by Pictou County Branch. Drs. H. B. Atlee, W. D.

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Stevenson, and Clyde Marshall were among the lecturers.

WOLFVILLE

The annual birthday dinner of Valley Branch was held in November with 45 members in attendance. Mary E. MacDougall, who is on leave from an African Mission and at present taking a post-graduate course at Nova Scotia Sanatorium, gave an interesting talk on her work in Africa, showing slides that she had taken.

ONTARIO

DISTRICT 1

BLENHEIM

Dr. H. Orr of Ridgetown was guest speaker at a meeting of Chapter 1 of the Chatham General Hospital School of Nursing Alumnae Association when they met at the home of Mrs. M.Sample. Fourteen members were present and heard an interesting talk on "The Rh Factor." The hostess introduced the speaker and he was thanked by Mrs. B. McMillan. A report for Kent County was given by D. Stevens and plans were made for the alumnae banquet to be held in Chatham. Mrs. J. McGuigan was the winner of the Dutch auction. Refreshments were served by D. Stevens, Mmes V. McGowan and McGuigan.

SARNIA

Rahno M. Beamish, General Hospital superintendent, received an official certificate of membership in the American College of Hospital Administrators at their 18th convocation held last fall.

STRATHROY

At a meeting of the General Hospital Alumnae Association, with I. Urquhart, the president, in the chair, Mrs. Mason announced the beginning of two sets of lectures—a course in St. John Ambulance emergency training and one on civil defence nursing. A film on "Aureomycin" was presented by Mr. R. Elliott. Refreshments were served by Mmes H. Frank, Jr., and O. Aikens.

At a later meeting plans were made for a dance, bazaar and bake sale. The Christmas meeting, in the form of a pot-luck supper, was also discussed, when children's gifts for the Firemen's Fund were to be collected.

A motion from the special nurses of the hospital and district was presented to the alumnae, asking that an increase in their rate of pay from $7.00 to $8.00 for an eight-hour shift be approved. This increase levels pay of Strathroy special nurses with that in effect in the remainder of the Middlesex area and this district of the R.N.A.O. The motion was approved.

The following officers were appointed: Honorary president, Mrs. B. Mason; president, I. Urquhart; vice-president, Mrs. J. Speirs; secretary, M. Grogan; treasurer, F. Riley. Other executive members include: G. McDonald, E. W. Hughes, A. Stevenson, H. Mabee, Mmes O. Aikens, M. Richardson, J. McLeish, F. McNeil, H. Pritchard, E. England, and A. Walker.

Refreshments were served by A. Stevenson, Mmes H. Pritchard and E. Evans.

District 3

Orangeville

W. Cooke, chairman, presided at the first annual meeting of District 3 when 88 members and 20 guests were present. The reports from the various conveners showed a successful year. Irene Weirs, district delegate to the C.N.A. biennial convention in Quebec City, described the various sessions and Miss Cooke reported on the R.N.A.O. Board of Directors' meetings. Mr. M. McKitrick, editor of the Orangeville weekly paper, addressed the afternoon session on the subject "Words—One of Woman's Greatest Weapons." O. Stewart thanked the speaker.

At the evening banquet members of the executive and those assisting with the program were seated at the head table and introduced by Miss Cooke. The special speaker was Rev. J. Bartlett whose theme was "An Englishman Looks at Canada." C. Adams expressed appreciation to the Rev. Bartlett for his remarks. R. Gaw gave the Resolutions Committee report and M. McFee, on behalf of the members, thanked Miss Cooke for her fine leadership during the past year.

An invitation from the Graduate Nurses' Association in Walkerton to hold the spring district meeting there in May was accepted with pleasure.

Elora

Graduate and student nurses came by chartered bus and private cars on Sunday, October 26, to St. John's Anglican Church, to attend the annual Nurses' Service. The special speaker for the occasion was the Rev. C. J. Loat of St. Thomas Anglican Church in St. Catharines who instituted the first Nurses' Service eight years ago when he was rector of the church in Elora. Since that time St. John's has become known as "The Nurses' Shrine."

Mr. Loat told the poignant love story of Florence Nightingale—"The Angel of the Crimea"—whom the sick and wounded referred to as "The Lady with the Lamp," and her cousin sweetheart whom she could not marry—the Rev. John Smithurst, who dedicated his life to the sacred ministry in the Red River district and later at Elora where he died and is buried.

Three nurses in uniform—Mrs. J. Steacy of Elora, Miss Raymond of Fergus, and L. Ennis of Whitely—distributed orders of service at the door. The rector, Rev. J. D. Tiller, conducted the service and welcomed the capacity congregation. Following the benediction, Mrs. Steacy led the graduate nurses in repeating The Nightingale Pledge.

Parts of the service were filmed by a motion picture company from Montreal.

Owen Sound

At a meeting of the General and Marine Hospital Alumnae Association, A. Cook reported on the bridges commencing in November.

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The following Nominating Committee was named: A. Matches, Mmes G. Gillesby and D. Fleming. Plans were discussed concerning a showcase in the hospital as a means of raising funds. R. Showell and Mrs. D. J. McMillan were appointed as co-conveners for this project. The guest speaker, Mrs. D. Cavers, was introduced by Mrs. W. Farrow. She gave an enjoyable talk on "How to Make a Success out of Life."

District 4

Welland

The Niagara Chapter held a meeting in November when the chairman, D. Sharpe, presided. Brief reports were given by the committee conveners and T. Finlayson, *Canadian Nurse* district convener, requested every member's assistance in promoting the circulation of the *Journal*. Two educational films were presented—"The Story of Dr. Jenner" (the smallpox story) and "Breakdown" (the schizophrenic's story). Miss Bradshaw, director of nursing at the County General Hospital, locale of the meeting, served lunch for those in attendance.

District 5

Toronto

The district members were guests of the Queen Elizabeth Hospital for the Chronically Ill in November. Following a brief business meeting, a film entitled "Ray of Hope" was shown. This depicted the various aspects of the work carried on by the hospital and served to prepare the visitors for the tours through the various departments. Guests were greeted by Pearl Morrison, superintendent, and her assistant, M. Kennedy. The visitors, representing all fields of nursing, were pleased to have observed the work of the hospital staff in rehabilitating patients with chronic conditions such as arthritis, paraplegia, poliomyelitis, etc.

District 7

Smiths Falls

About 100 members of the district, including nurses from Brockville, Kingston, Perth, and Smiths Falls, attended a meeting held at the Ontario Hospital here. Following the business session, F. McIntyre of the hospital staff, introduced Dr. H. Frank, medical superintendent, who gave an address on "Child Welfare and Mental Health." He outlined the part played by mental hospitals in a community.

Kingston

Ontario Hospital

Mrs. R. Turney, a member of the Cerebral Palsy Parent Council for Kingston, spoke to a large group of members of the alumnae association at a meeting held at the home of Mrs. R. Burke. Mrs. Turney (formerly Grace Belyeau) is a graduate of the Kingston General Hospital and served on the staff of the Ontario Hospital several years ago.

The group learned that there are 28 children in Kingston (60 in the district) who are urgently in need of the specific treatment which can only

be provided privately by highly trained therapists at great expense to the parents. Such treatment is given with good results at a centre near Woodeden. Mrs. Turney was introduced by Mrs. Burke, a member of the Ladies' Lions Club, who sponsored the council in Kingston for 1952, and was thanked by the alumnae president, Mrs. N. R. Ferguson. The nurses voted $50 to the council for purchase of equipment and it was suggested that more help for this worthy cause might be undertaken as a project for this year. E. G. Smith, superintendent of nurses at the Ontario Hospital, reported that the student nurses had had a speaker and film on the Woodeden Cerebral Palsy Centre.

Mrs. Ferguson urged all nurses to learn the new method (Holger-Nielsen) of artificial respiration adopted by groups rendering first aid.

District 8

Ottawa

Civic Hospital

The annual bazaar of the Civic Hospital Alumnae Association was well patronized and proved highly successful.

General Hospital

An interesting outline of the main activities of the Department of Psychiatry of the General Hospital was given by Dr. Karl Stern at a meeting of the alumnae of the General Hospital and the University of Ottawa School of Nursing. Mrs. D. B. Kipp, president of the O.G.H. alumnae, was in the chair. Dr. Stern, who is head of the Psychiatric Department of O.G.H., was introduced by J. Stock and thanked by Mrs. N. Chassé. Nurses and social workers left the meeting with a clearer picture of the methods used in the psychiatric department of a modern hospital. Dr. Stern said that a psychiatric ward filled a community need, supplying treatment for many borderline cases who do not need to be sent to a mental hospital.

District 11

Barrie

Mrs. A. Fraser was elected president of the Royal Victoria Hospital Alumnae Association at the opening meeting of the fall season. The Alumnae voted $500 toward the furnishings of the classroom in the new residence. At the conclusion of business, Mmes Fraser and Rowe favored the group with piano and mouth organ selections.

Additional executive members include: Vice-presidents, Mmes L. Cunningham, R. Usher; secretary, O. Clute; treasurer, Mrs. J. Garvin.

PRINCE EDWARD ISLAND

At a regular meeting of Charlottetown District held in December, a discussion occurred concerning the possibility of a refresher course in pediatrics and the advisability of inviting mothers of young children to attend, reference being made to the success of a similar course some years ago. Dr. T. A. Laidlaw gave an

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informative address on "Surgery of the Gallbladder", explaining the present-day technique and treatment of the disease. An excellent film was shown on uterine cancer, revealing how an early diagnosis could be made when the cancer was still in "Stage O"—that is, before it could be revealed by a physical examination. Approximately 60 nurses were in attendance.

Mrs. G. MacKay, the president, was in the chair at the November meeting of the Community Nursing Registry in Charlottetown. It was noted that the membership for the first six months of the year was 53, dropping to 41 for the last half of 1952. Plans were made for a dance and for a White Elephant Sale.

At a bi-monthly meeting of the Prince Edward Island Hospital Alumnae Association, with the president, Mrs. L. Vatcher, in the chair, $25 was voted towards the Nurses' Registry. A prize for the highest marks in the R.N. exams for a 1952 P.E.I. Hospital graduate was presented to Janet Ives. The business meeting was followed by a very successful plastic demonstration.

The 13th annual meeting of St. Veronica's Guild was held at Charlottetown Hospital in October when the Rt. Rev. Msgr. M. MacDonald celebrated Benediction prior to the meeting. The president, Mrs. J. Callaghan, reviewed the year's activities. She reported that the home-cooking booth, sponsored by the nurses at the hospital bazaar, realized $242. A letter was read from Sr. Superior, expressing thanks for a cheque received from the Guild to help purchase the stainless steel equipment for the pediatric department. It was also decided to buy a children's record player.

On behalf of the members, gifts were presented by P. Hughes to E. Diamond, K. Read, L. Trainor, and T. McKinnon who will take positions in Ontario. Music by Mr. H. Wood and a sing-song were enjoyed. Refreshments were served by: D. MacKenzie, L. Poirier, G. Arsenault, Mmes Leonard, R. Richard, A. Gaudet, E. MacGuigan.

The following officers will serve during the coming months: Honorary president, M. King; president, Mrs. J. Callaghan; vice-presidents, Mrs. G. J. Maddigan, L. Poirier; corresponding secretary, A. Trainor; secretary-treasurer, Mrs. J. E. Corrigan. The executive committee is composed of: E. MacDonald, Mmes H. Murphy, E. MacGuigan, and E. Burke.

QUEBEC

MONTREAL

General Hospital

A farewell tea was held in December for Miss Latta who has been in charge of the O.P.D. of the Western Division for many years and for P. Coates who has also been on the staff of the Western.

The following are attending McGill School for Graduate Nurses: Public health—B. Arkright, J. Gair, C. Miller, D. Parker, M. Smith; teaching, V. Crouse; administration, A. Hornibrook. A. Christie has left South Africa for England.

Royal Victoria Hospital

A highlight of the alumnae tea was a musical program presented by Joan Ford and Dennis Whyte. Patients and staff greatly appreciated the Christmas carol programs presented by the choirs of the various churches.

J. Atkinson and B. Evans are taking a post-graduate course in surgery at Guy's Hospital, London, Eng. D. Allison is nursing in Seattle. E. Banks is on the staff of the Ross Memorial Diagnostic Clinic while Anne Gilbert is in Saint John, N.B. L. Wright has resigned from the staff to be married.

SHERBROOKE

A number of English nurses have arrived and are now on the staff of Sherbrooke Hospital. Among them is Miss Davies, the new instructor for the school of nursing.

Monthly meetings of the alumnae are being held. The nurses' dance was a social and financial success, the general convener being Mrs. H. Grundy, assisted by B. Boyd, D. Whitcher, Mmes H. Griffin and W. Chisholm. Conveners for the fall raffle and rummage sale included Mmes N. Coates, E. Lavallée and Webster. The members heard with interest the report of Miss Beckwith, clinical supervisor, on the C.N.A. biennial convention in Quebec.

It was with regret that a farewell was bid to Vera Graham, superintendent of nurses, who has worked strenuously for the school of nursing and the hospital. She was presented with a gift on behalf of the alumnae. K. Vaughan is now supervisor of the children's ward. I. Miller is in charge at the Elizabeth Crowe Memorial Hospital, Eriksdale, Man.

SASKATCHEWAN

MOOSE JAW

The Christmas party of Moose Jaw Chapter was held at the General Hospital in December when 136 members were present. Lola Wilson, S.R.N.A. registrar, gave an informative talk on "The Centralized School of Nursing Plan." Mr. F. Godley later entertained with selections on the Hammond organ.

REGINA

A Nursing and Nursing Education Institute was held in November at Grey Nuns' Hospital, sponsored by the Catholic Hospital Conference of Saskatchewan and the Grey Nuns' Hospital School of Nursing. Highlights included discussion on group dynamics and a seminar on "Modern Trends in Nursing Education" with Misses Turner (leader), Kenney, McKenzie, and Davidson participating. Demonstrations were held of the Ward Manual, ward teaching, teaching correlation board, and the bioscope. Other speakers and topics were as follows: Key to Success in the Nursing Team, E. Jefferson; Ward Clerk Philosophy, Sr. Bezaire, superior, St. Paul's Hospital; The Ward Clerk in Action, P. Stack, ward clerk; Public Relations of the Nurse, Mr. Bourassa, business manager, G.N.H.; New Developments in Civil Defence Teamwork, Mr. Probie, Sask. C.D. Dept.; The Patient's Moral Comfort: a Responsibility of the Nurse, Rev. Father Molloy; Newer

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CASH'S: 3 Doz. $1.80; 9 Doz. $3.60; NO-SO NAMES: 6 Doz. $2.40; 12 Doz. $3.50; 25¢ per tube

Methods of Teaching in Nursing Education, H. Keeler; Nursing Experience Record, Sr. A. Levasseur; R.N. Means "Real Nurse," E. Smith.

Dr. M. G. Israels was guest speaker at a meeting of Regina Chapter when he stated that international meetings in the majority of medical specialties have encouraged travel by many physicians. He described the highlights of his trip to England when he visited a number of London hospitals, including Hammersmith and the British Post-Graduate School. His travels also took him to Holland, Belgium, Switzerland, Italy, and France.

SASKATOON

Following a meeting of Saskatoon Chapter, a social evening was held at the City Hospital when music and the preparation and serving of refreshments was in charge of the Student Nurses' Association. Several out-of-town guests attended, including: L. Wilson, H. McGrath, Sr. Brodeur, all of Regina; Mrs. J. Porteous, St. Catharines, Ont.; Mrs. J. O'Brian, Niagara Falls, Ont.; G. Motta, Moose Jaw.

City Hospital

Twenty-seven graduates of S.C.H. attended a reunion in Toronto in October when Mrs. A. B. Davidson entertained at her home at Thornhill. A banquet followed at the Royal York Hotel when Mrs. J. Porteous, a graduate of the hospital and former director of nurses, was the speaker. A tour of Sunnybrook D.V.A. Hospital the following afternoon rounded out the activities, Mrs. J. B. Horner of Willowdale entertaining the nurses with a buffet supper. Mmes Johnson and Robinson, assisted by a committee of those in and around Toronto, were conveners for the event.

Fourteen graduates, now living in Calgary, were present at a reunion party held in November, when H. Gruhlke was the hostess. Classes from 1930 to 1952 were represented.

New staff members include: L. M. Barber, J. Colenutt, B. MacKenzie, H. Gayton, M. E. Kennedy, J. Mackin, C. Markham, M. Stamm, G. Williams, R. Alcorn, G. Ahearn, G. Blachford, E. (Lane) Ellery, R. (Haugen) Hesje, M. (McCann) Domes, S. (Svetkov) Leo, S. (Edwards) Skolrus, P. (Dobrichan) Matiko, M. (Humphreys) Hewitt, J. (Hamilton) Sharp. G. (Roberts) Arbic was a recent visitor at the hospital.

St. Paul's Hospital

A candlelit procession of student nurses, led by an "angel" bearing the "Divine Infant" and attended by four "cherubs," brought joy to the patients by melodious singing of Christmas songs. The annual Christmas concert, the preliminary students contributing the largest part, was a great success. The announcement of Sr. Superior's gift to the school—a toaster—added a note of joy. Block II and III students held a skating party and also paid a surprise visit to the various old people's homes in the city to sing carols.

Saskatoon Sanatorium

New staff members include: L. Buckley, K. Hawrysh, Y. Quaale, L. Wirchenko, A. Fischbuck, J. Eckdahl, H. McPherson, A. McGowan, V. Weiss, A. Mann, M. (Darling) Olsen. The following have resigned: H. (Chow) Paterson, to go to Lethbridge, Alta.; D. Carter, to join the staff of Delisle Hospital, Sask.; G. Chattergoon, to continue studies at Teachers College, Columbia University.

Positions Vacant

Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.

Orthopedic Nurse (experienced, qualified). Salary: $12.50 per day; $13.50 afternoons & nights. Desirable personnel policies. 45 min. from Detroit, 3 miles from Selfridge air force base. Apply Director of Nursing, St. Joseph Hospital, Mt. Clemens, Michigan.

General Duty Nurses — "You will like it here." Placement in the service of your choice in Teaching Hospital. Beginning salary: $240 per mo. for 40-hr. wk. Scheduled increases, payment for overtime, 6-hr. evening duty, $270 per mo. for night duty. Sick leave, 6 holidays, 3 wks. vacation. Residence facilities if desired. Tuition-free courses after 6 mos. service. Opportunities for advancement. Apply Director of Nursing Service, University Hospitals of Cleveland, Cleveland 6, Ohio.

General Duty Nurses for all services for Apr. 1 in new 75-bed hospital. Beginning salary: $260. 40-hr. wk. $20 additional for 3-11 p.m.; $10 additional for 11-7 a.m. 2 wks. vacation with pay. 7 holidays. Sick leave. Apply Director of Nursing Service, Mercy Hospital, Redding, California.

Graduate Nurses for 20-bed hospital. Salary: $150 plus full maintenance. Transportation paid. 1 mo. vacation. Apply Matron, Katherine H. Prittie Hospital, Bonnyville, Alta.

Graduate Nurses for General Duty. Starting salary: $235 with B.C. registration. R.N.A.B.C. working agreement. New 100-bed hospital provides modern equipment & pleasant surroundings. Good living accommodation. Apply Supt. of Nurses, West Coast Hospital, Port Alberni, Vancouver Island, B.C.

Graduate Nurses for General Duty (2) immediately for 30-bed hospital on Canadian Pacific main line, 90 miles east of Calgary. Starting salary: $160 plus full maintenance, increasing to $170 when qualified. Straight 8-hr. shift, rotating. Vacation pay, sick pay, free hospitalization, accident indemnity, etc. Apply Matron, Municipal Hospital, Bassano, Alta.

Public Health Nurse for Lennox & Addington County Health Unit. Present minimum salary: $2,400. Suitable adjustments made in salary for experience. Car allowance on mileage basis. 4 wks. vacation. 5½-day wk. Cumulative sick leave at rate of 1½ days per mo. Apply Dr. J. I. Jeffs, Lennox & Addington County Health Unit, Memorial Bldg., Napanee, Ont.

Public Health Nurse for Elgin-St. Thomas Health Unit staff. Minimum salary: $2,230. Maximum salary: $2,950. Suitable adjustments made for experience. Car allowance, $720 per yr. 4 wks. vacation & cumulative sick leave up to 90 days at rate of 1½ days per mo. unexpended. Pension plan. Interest-free loan if necessary for purchase of car. Apply Supervisor of Nurses, City Hall, St. Thomas, Ont.

Public Health Nurses for St. Catharines-Lincoln Health Unit. Generalized program. Salary: $2,400; allowance for public health experience. Annual increment. Transportation allowance. Apply Director of Nursing, Health Unit, St. Catharines, Ont.

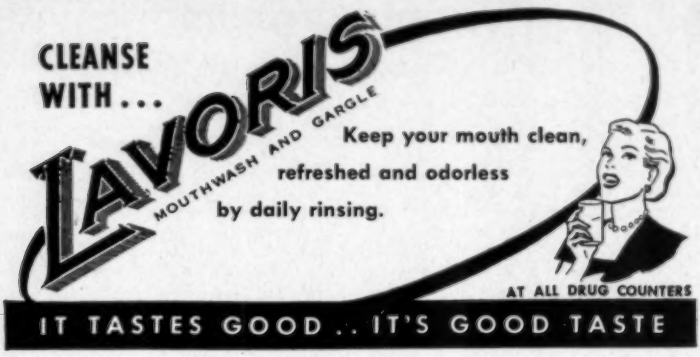
Administrative Asst. of Nursing Service. Salary: $15 per day for qualified person. Desirable personnel policies. 45 min. from Detroit, 3 miles from Selfridge air force base. Apply Director of Nursing, St. Joseph Hospital, Mt. Clemens, Michigan.

Head Nurse — Nursery & Delivery Room. Experienced. Beginning salary: $13.50 day; $14.50 afternoon & night. Desirable personnel policies. 45 min. from Detroit, 3 miles from Selfridge Air Force Base. Apply Director of Nursing, St. Joseph Hospital, Mt. Clemens, Michigan.

Head Nurse—Surgical Floor & Medical Floor. Experienced. Beginning salary: $13.50 day, $14.50 afternoon & night. Desirable personnel policies. Hospital 20 miles from Detroit, 3 miles from Selfridge Air Force Base. Apply Director of Nursing, St. Joseph Hospital, Mt. Clemens, Michigan.

Registered Nurses for St. Joseph Hospital, Mt. Clemens, Michigan, 25 miles north of Detroit, near Selfridge Air Force Base. Optional 40- or 44-hr. wk. **Staff Nurses:** $12 day duty; $13 afternoon or night duty. State Standards. Apply Director of Nursing Service.

Asst. Director of Nurses & General Duty Nurses. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.



Clinical Supervisor (qualified) for The Victoria Public Hospital, Fredericton, N.B. For details apply Director of Nurses.

Registered Nurses for supervisory positions & staff nursing for new & beautifully equipped 100-bed hospital in Oregon, U.S.A. Excellent salaries & 40-hr. wk. Apply Director of Nurses, County General Hospital, Tillamook, Oregon.

General Duty Nurse for 107-bed modern hospital. Starting salary: $165 per mo. plus meals & laundry. Additional for each evening or night shift. Increases at 6 mos. & annually thereafter for further 2 yrs. 44-hr. wk. 8 statutory holidays. 21 days holiday with pay. Travelling expenses refunded after 6 mos. from point of entry into Ont. Cumulative sick time. Medical & hospital plan subsidized. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

Public Health Nurse (qualified) immediately for City of Ottawa Health Dept. Salary range: $2,280-2,640 plus generous Cost of Living Bonus. Generalized public health nursing program. Good personnel policies. 3 wks. vacation annually. Superannuation & Blue Cross benefits. Apply Dr. J. J. Day, Medical Officer of Health, Transportation Bldg., 48 Rideau St., Ottawa 2, Ont.

Asst. Director immediately. Charge of educational program. Basic diploma course. 150 students. 360-bed General Hospital. 15-min. drive from heart of Cincinnati, Ohio. Salary: $350. 40-hr. wk. 4 wks. annual vacation. Degree required. Roman Catholic preferred. Experience considered. Apply c/o Box F, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Matron (1) & Nurse (1) for Union Hospital, Lucky Lake, Sask. Salaries: $225 & $180 plus maintenance, respectively. Apply G. D. Clark, Sec.-Treas., Lucky Lake, Sask.

Nursing Arts Instructor; Supervisor & Clinical Instructor — Medicine; Supervisor & Clinical Instructor — Surgery; Supervisor & Clinical Instructor — Gynecology. All positions open now at School of Nursing, General Hospital, Hamilton, Ont. Address applications & requests for further information to Director of Nursing.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $83 plus Cost of Living Bonus of approx. $6.00 per wk. 44-hr. wk. For other perquisites & further information apply C. E. Brewster, Supt. of Nurses.

Graduate Floor Duty Nurses for Mount Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $83 plus cost of Living Bonus. For other perquisites & further information apply Supt.

General Duty Nurses. Salary: $173.23 (one hundred seventy-three dollars & twenty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

General Duty Nurses for 611-bed General Hospital with School of Nursing. Salary: $273; increase $15 end of 1st yr.; $17 end 2nd & 3rd yr.; $19 end 5th yr. Differential of $10 for special services & p.m. & night duty. 40-hr. wk. 12 paid holidays. 3 wks. vacation. Free laundry. Cumulative sick leave. Housing available. Apply Director of Nursing Service, General Hospital, Fresno, California.

VICTORIAN ORDER OF NURSES FOR CANADA

has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

- Opportunity for promotion.
- Transportation while on duty.
- Vacation with pay.
- Retirement annuity benefits.

For further information write to:

Chief Superintendent,
Victorian Order of Nurses for Canada,
193 Sparks Street,
Ottawa 4, Ont.

O.R. Scrub Nurse. Also **General Duty Nurses (2)** for 320-bed Sanatorium for Tuberculosis. For further information apply Director of Nurses, Fort William Sanatorium, Fort William, Ont.

Science & Nursing Arts Instructors (one of each). New hospital to open this year. Salary open. Apply Supt. Charlotte County Hospital, St. Stephen, N.B.

Obstetrical Supervisor with special preparation. Gross minimum salary: $240 — annual increments. Vacation, sick time. 48-hr. wk. For further details apply Supt. of Nurses, General Hospital, Moose Jaw, Sask.

Clinical Instructor (Psychiatric Nursing). Salary: $248-298 per mo. **General & Psychiatric & General Graduate Nurses.** Salary: $198-248 per mo. Salaries depend on qualifications & experience. 44-hr. work wk. Uniforms supplied. Modern residence. $30 charge per mo. for perquisites. Excellent holiday, sick leave & pension benefits. Apply, stating qualifications & experience, Supt. of Nurses, Provincial Mental Hospital, Ponoka, Alta.

Operating Room & Maternity Nurses. Salary: $162.50 for recent graduates. Two meals, laundry. 8-hr. day—straight shift. $15 differential evenings—$10 nights. Vacation, sick time & statutory holidays on salary. Semi-annual & annual increments. Financial recognition for years of experience, post-graduate or university study. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

Operating Room Supervisor (special preparation preferred). Also **Dietitian & Night Supervisor** for 100-bed hospital. Salary depends on qualifications & experience. Apply Soldiers' Memorial Hospital, Campbellton, N.B.

Dietitian (qualified) for Teaching Hospital. Opportunity for advancement. Full maintenance. Fare from Canada for accepted candidate. For full particulars write, giving qualifications & date available, Matron, King Edward VII Memorial Hospital, Bermuda.

Asst. Dietitian (qualified) for 225-bed hospital. Apply Chief Dietitian, Moncton Hospital, Moncton, N.B.

Head Nurse for 30-bed Pediatric Unit in 100-bed Children's Hospital. All-graduate staff. Experience in charge work as well as pediatric knowledge essential. R.N.A.B.C. recommendations. For further information apply Director of Nursing, Children's Hospital, 250 W. 59th Ave., Vancouver 15, B.C.

General Duty Nurses for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $240-270. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses for Obstetrical, Medical & Surgical Depts. Living-in accommodation available temporarily. For information apply Director of Nurses, General Hospital, Woodstock, Ont.

General Duty Nurses. Positions open 30 miles from New York City. Salary: $210-220 for 40-hr. wk., 8-hr. day 3 wks. vacation. 7 paid holidays. 12 days sick leave. Also **Operating Room Nurses** at higher salaries. Apply Administrator, Ossining Hospital, Ossining-on-Hudson, New York.

WANTED

OPERATING ROOM SUPERVISOR

The *Victoria Hospital* in *London, Ontario,* has an opening for a trained and experienced **Operating Room Supervisor** for an active Surgical Department.

• **EXCELLENT PERSONNEL POLICIES** • **GOOD SALARY**

Apply — **DIRECTOR OF NURSING, VICTORIA HOSPITAL, LONDON, ONT.**

• WANTED •

for 200-bed Hospital

Head Nurses for ***Obstetrical, Pediatric*** and ***Surgical Floors,*** and **General Duty Nurses**

• **3 WEEKS' VACATION** • **8 STATUTORY HOLIDAYS** • **2 WEEKS' SICK LEAVE**

Apply:

Director of Nurses, The Greater Niagara General Hospital
Niagara Falls, Ontario

Municipal Nurses for the Province of Alberta. Rural service, emergency treatment, preventive & maternity program. Salary: $2,160-3,000 depending on qualifications & experience, plus modern furnished cottage. Excellent sick leave, pension & vacation benefits. Apply Director, Nursing Division, Dept. of Public Health, Administration Bldg., Edmonton, Alta.

General Duty Nurses for large General Hospital. Openings available in all depts., including pediatrics & isolation, for nurses interested in permanent positions. Apply Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses for modern 50-bed hospital. Gross salary: $215 less $40 board & lodging. $10 annual increase. 10 statutory holidays. 4 wks. annual vacation. 1½ days sick leave per mo. cumulating to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply Administrator. Wrinch Memorial Hospital, Hazelton, B.C.

Graduate Nurses for completely modern West Coast hospital. Salary: $230 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Also **O.R. Supervisor**. Salary: $270 per mo. Working conditions & perquisites same as nurses. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Graduate Nurses for modern well equipped Teaching Hospital in Central California. Salary: 273-320 per mo. 40-hr., 5-day wk. Liberal vacation. Holiday & sick leave plan Apply Personnel Office, 510 E. Market St., Stockton, California.

Registered Nurses with Public Health training & experience, preferably generalized Not over 35 yrs. of age. Initial salary: $2,700 with annual increment. Pension scheme available. Apply Director, Nursing Service, Ontario Society for Crippled Children, 92 College St., Toronto 2, Ont.

PROVINCIAL GOVERNMENT OF NEWFOUNDLAND
CANADA
DEPARTMENT OF HEALTH

St. John's General Hospital
St. John's—Newfoundland

Applications are invited for the post of **Associate Director of Nursing Education.** The occupant of this post will be required to assume charge of the School of Nursing for the above Hospital and be responsible generally to the Director of Nurses for the implementation of the Teaching Program. The student enrolment is approximately 150, with affiliations to accredited hospitals in Obstetrics, Psychiatry, and Tuberculosis.

Salary — $1,740-50-1,890, together with Cost of Living Bonus presently amounting to $240 per annum; full maintenance; modern living quarters, including meals, uniforms and laundry; annual vacation of 24 working days, which may be accumulated to a maximum of 48 working days for the purpose of overseas leave, together with statutory holidays as they occur.

Applications, stating age, qualifications, experience, references, etc., should be addressed to:

The Superintendent, St. John's General Hospital, St. John's, Newfoundland.

Registered Nurses for General Duty for small General Hospital. Salary: $140 per mo. with full maintenance. 6-day wk. 8-hr. duty, rotating shifts. 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holiday. Apply Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses for General Duty in busy 70-bed General Hospital. Commencing salary: $180 per mo. for 44-hr. wk. Good personnel policy. Apply Supt., Ross Memorial Hospital, Lindsay, Ont.

Supervisor by March 1 for small active **Psychiatric Unit** with additional out-patient clinics & plans for expansion. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

Night Supervisor (11:00 p.m.-7:00 a.m.) for 60-bed Pediatric-Orthopedic Hospital. Also **Asst. Head Nurses.** Apply Director, Shriners' Hospitals for Crippled Children, Montreal 25, Que.

Registered Nurses (4) to be in charge of 22-bed hospital while on duty. Salary: $13 per 8-hr. day. Apply Harworth Hospital, 531 E. Grand Blvd., Detroit 7, Michigan.

Graduate Nurses (2) for Burns Lake Hospital, Burns Lake, B.C. Salary: $215 per mo. ($220 if B.C. registered) less $40 for full maintenance. 4 wks. vacation with pay plus usual statutory holidays. Fare refunded after 6 mos. Return fare after 1 yr. Apply Supt.

General Staff Nurses for medical, surgical & obstetrical floors. 177-bed hospital with Training School. Salary: $180-195 gross, depending on experience. $30 charge for room & board. 44-hr. wk. 2½ days holidays per mo. cumulative to 30 days. Apply Mrs. M. Alexander, Acting Director of Nurses, General Hospital, Medicine Hat, Alta.

General Staff Nurses for new small hospital. Rotating straight shifts. 45-hr. wk. 4 wks. vacation. 2 wks. sick leave with pay after 1 yr. service. Salary: $150 per mo. with full maintenance. Increases each 6 mos. Apply Supt., Niagara Hospital, Niagara-on-the-Lake, Ont.

Graduate Nurses for General Duty (2) for 30-bed hospital. Salary: $165 per mo. with full maintenance. $5.00 per mo. increase after each 6 mos. service. Vacation & sick leave with pay. New residence on grounds. Good recreational facilities in modern town, close to city & Waterton National Park. Write or phone Matron, Municipal Hospital, Cardston, Alta.

A WAIVER IN ONTARIO UNDER THE NURSES' REGISTRATION ACT — 1951

Notice is hereby given that the regulations under the Nurses' Registration Act, 1951 (Ontario) include a waiver which reads as follows:

"The Board shall register without examination any person
(a) who
  (i) graduated from a school of nursing, and
  (ii) was eligible for registration as a registered nurse under any Act of this Legislature before the year 1926; and
(b) who has not registered as a registered nurse where that person
(c) applies for registration before the 31st of December, 1953, and
(d) pays the registration fee prescribed by sub-Regulation 2 of Regulation 12."

This means that nurses who graduated from an approved school of nursing *prior to 1926*, but who did not register at that time, now have a second opportunity to register without examination. This opportunity is good until ***December 31st, 1953.***

Individual application for registration under the waiver should be made to:

The Registrar, Registered Nurses' Association of Ontario,
515 Jarvis Street, Toronto 5, Ontario.

Registered Nurses for General Floor Duty. Rotating shifts. Apply Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg, Que.

Registered Nurses for Floor Duty. Also **Operating Scrub Nurse (1).** Modern 50-bed General Hospital with good working conditions & attractive salary. Apply Supt., District Memorial Hospital, Leamington, Ont.

Registered Nurses for General Duty for 50-bed hospital in town on Lake Ontario, near Toronto. 44-hr. wk. Salary: $180 per mo. with additional $10 for 4-12 duty. Apply Supt. of Nurses, General Hospital, Cobourg, Ont.

Registered Nurses for General Duty in 70-bed General Hospital in San Gabriel Valley, 40 min. from Los Angeles. Close to beaches & mountains. 40-hr. wk. 2 wks. paid vacation. 6 mos. increase in salary. Paid hospital insurance. Starting salary: $235 per mo.; $10 differential for afternoons & nights; $10 differential for surgery & maternity. Write for application form Supt. of Nurses, Inter-Community Hospital, Covina, California.

Supervisor of Nurses for 80-bed hospital in Montreal. Good wages, nice working conditions, excellent prospects with this expanding, modern hospital. All applications strictly confidential. Apply with full details c/o Box N, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Registered Nurses with knowledge of French for new 20-bed hospital. Starting salary: $150 plus maintenance & laundry. 8-hr. rotating shifts. Apply Matron, Gatineau Memorial Hospital, Wakefield, Que.

General Duty Nurses. The jingle of wedding bells — our loss! Last year 7 of our nurses, several of them Canadian trained, left us to be married. Starting salary: $260 per mo. & meals equal to another $45 per mo. Short work wk., group insurance, vacation pay, brand new hospital & pleasant community in which to live. Write in a hurry to Memorial Hospital, Cut Bank, Montana.

Public Health Nurse (qualified) by Apr. 1 for generalized service in City of Guelph. Minimum salary: $2,400 with allowance for experience. Apply Supervisor of Nurses, Health Dept., Guelph, Ont.

● VANCOUVER GENERAL HOSPITAL ●

● The Vancouver General Hospital invites immediate enquiries from *Graduate Nurses for Staff Vacancies* in order to implement 40-hour week.

SALARIES of $226.50 as minimum and $263.25 as maximum, plus shift differentials for Evening and Night Duty approved for 1953.

Please apply to:

Personnel Dept., General Hospital, Vancouver 9, B.C.

Applications should be accompanied by letter of acceptance of registration in B.C. from ***Registrar of Nurses, 1101 Vancouver Block, Vancouver 2, B.C.***

ANESTHESIA

A career specialty for the Graduate Nurse. **Eligibility:** Graduates of Accredited Schools of Nursing. **Course:** Study of the basic sciences related to Anesthesia. Clinical training in all phases of General Anesthesia, Resuscitation, and Inhalation Therapy. **Professional Opportunities:** Full-time position in teaching and non-teaching hospitals in United States. For special course write: **Mary H. Snively, R.N., In Charge of Nurses' Training Programs, Duke Hospital, Durham, North Carolina.**

Operating Room Supervisor with post-graduate course & some experience for 75-bed hospital with School of Nursing (new addition under construction including complete new operating suite). Present salary: $210 per mo. plus meals & laundry. Room can be made available if absolutely necessary. Apply, with references, Director of Nursing, Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.

General Duty Staff Nurses for 515-bed General Hospital. 40-hr. wk. Beginning salary: $250 per mo. with advancement to $270; $20 additional for evenings & nights. Hospital & School of Nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

Central Alberta Sanatorium, Calgary, Alberta, offers to Graduate Nurses a six-month Post-Graduate Course in Tuberculosis. Maintenance & salary as for General Staff Nurses. Opportunities for permanent employment if desired. Spring & Fall Classes. Further information on request.

Supt. of Nurses for modern 75-bed General Hospital in suburbs of Montreal. Apply in writing, giving qualifications, references & salary expected, c/o Box W, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Registered Nurse for General Duty in 600-bed Tuberculosis Hospital, 6 miles from London, Ont. Initial salary: $175 gross, less $33 per mo. for board, room, laundry. Staff education program. Busy surgical ward. 44-hr. wk. For other perquisites — vacation, illness, pension & further information — apply Director of Nurses, Beck Memorial Sanatorium, London, Ont.

Registered Nurse for 8-bed hospital. Salary: $210 per mo. If full maintenance is desired, it will be provided for at $30 per mo. Address or phone inquiries to Mr. J. E. Hunter, Sec.-Treas., Union Hospital, Hodgeville, Sask.

General Staff Nurses for 80-bed hospital. For particulars apply Director of Nursing, Norfolk General Hospital, Simcoe, Ont.

Night Supervisor, $220; **Scrub Nurse for Operating Room,** $210; **Floor Duty Nurse,** $190; — per mo. for 50-bed hospital on Lake Ontario. Apply Supt., Port Hope Hospital, Port Hope, Ont.